# MISSISSIPPI CODE 1972
*Annotated*

Insurance
(83-21-1 to 83-71-115)

## Title 83

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# MISSISSIPPI CODE

# 1972

## *ANNOTATED*

ADOPTED AS THE OFFICIAL CODE OF THE
STATE OF MISSISSIPPI
BY THE
1972 SESSION OF THE LEGISLATURE

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## VOLUME NINETEEN A

## INSURANCE

## §§ 83-21-1 to 83-71-115

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CONTAINING PERMANENT PUBLIC STATUTES OF MISSISSIPPI
TO THE END OF THE 2011 REGULAR LEGISLATIVE SESSION

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4456611

ISBN 978-1-4224-9457-8 (Volume 19A)
ISBN 978-0-327-09628-3 (Code set)

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*www.lexisnexis.com*

(Pub.44510)

# PREFACE

The Mississippi Code of 1972, which became effective on November 1, 1973, is the culmination of nearly four years of effort on the part of the Legislature, the Attorney General's office and the publishers, which brings together provisions of general statutory law having a common subject matter into a more orderly and logical framework of code titles and chapters, and employing a modern and effective section numbering system. A major by-product of the code revision will be the state-owned magnetic computer tape containing the Mississippi Code of 1972, which will be of invaluable assistance to the Legislature and to the state.

The enabling act for the code was a recommendation of the Mississippi State Bar, which resulted in the consideration and passage of Senate Bill 1964, Chapter 465, Laws of 1970, signed into law by Governor John Bell Williams.

The Code Committee provided for in that act was comprised of A. F. Summer, Attorney General, Heber Ladner, Secretary of State, Representative Edgar J. Stephens, Jr., Chairman, House Appropriations Committee, Senator William G. Burgin, Jr., Chairman, Senate Appropriations Committee, Representative H. L. Meredith, Jr., Chairman, House Judiciary "A" and Judiciary en banc Committees, Senator E. K. Collins, Chairman, Senate Judiciary "A" and Judiciary en banc Committees, Representative Ney McKinley Gore, Jr., Chairman, House Judiciary "B" Committee, and Senator William E. Alexander, Chairman, Senate Judiciary "B" Committee. In 1972, Representative Marby Robert Penton and Senator Herman B. Decell, Chairman of House and Senate Judiciary "B" Committees, respectively, became members of the Committee, replacing Representative Gore and Senator Collins, Senator Alexander having been appointed Chairman of Senate Judiciary "A" and Judiciary en banc Committees. The Deputy Attorney General, Delos H. Burks, served the Code Committee as Secretary. Special Assistant Attorney General Fred J. Lotterhos, under the supervision of the Attorney General, was assigned the principal responsibility for the supervision of the recodification, including the consideration and treatment of some 16,000 sections of code manuscript.

Final legislative approval was given to the Mississippi Code of 1972 by passage of Senate Bill 2034, Laws of 1972, which was signed by Governor William L. Waller on April 26, 1972. A copy of that act is set out in Volume 1, following the Publisher's Foreword.

The Code Committee is of the opinion that the recodification has been thoroughly and well accomplished, and will result in a greatly improved repository of the general statutory law of the state.

A. F. Summer
Attorney General

# PUBLISHER'S FOREWORD

This newly compiled 2011 Replacement Volume 19A of the Mississippi Code of 1972 Annotated represents material appearing in the original 1973 Volume 19, the 1991 Replacement Volume 19 and the 1999 Replacement Volumes 19 and 19A, as well as reflecting amendments, repeals, and new Code provisions enacted by the Mississippi Legislature through the 2011 Regular Session.

This volume contains the text of Title 83, Chapters 21 through 71, of the Mississippi Code of 1972 Annotated, as amended through the 2011 Regular Legislative Session.

Case annotations are included based on decisions of the State and federal courts in cases arising in Mississippi. Many of these cases were decided under the former statutes in effect prior to the enactment of the Code of 1972. These earlier cases have been moved to pertinent sections of the Code where they may be useful in interpreting the current statutes. Annotations to collateral research references are also included.

To better serve our customers by making our annotations more current, LexisNexis has changed the sources that are read to create annotations for this publication. Rather than waiting for cases to appear in printed reporters, we now read court decisions as they are released by the courts. A consequence of this more current reading of cases, as they are posted online on LexisNexis, is that the most recent cases annotated may not yet have print reporter citations. These will be provided, as they become available, through later publications.

This publication contains annotations taken from decisions of the Mississippi Supreme Court and the Court of Appeals with decision dates through August 17, 2010, and decisions of the appropriate federal courts with decision dates through May 27, 2010. These cases will be printed in the following reporters:

Southern Reporter, 3rd Series
United States Supreme Court Reports
Supreme Court Reporter
United States Supreme Court Reports, Lawyers' Edition, 2nd Series
Federal Reporter, 3rd Series
Federal Supplement, 2nd Series
Federal Rules Decisions
Bankruptcy Reporter

Additionally, annotations have been taken from the following sources:

American Law Reports, 6th
American Law Reports, Federal Series
Mississippi College Law Review
Mississippi Law Journal

Finally, published Opinions of the Attorney General and opinions of the Ethics Commission have been examined for annotations.

## PUBLISHER'S FOREWORD

A comprehensive Index appears at the end of this volume.

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For further information or assistance, please call us toll-free at (800) 833-9844, fax us toll-free at (800) 643-1280, e-mail us at customer.support@bender.com, or write to: Mississippi Code Editor, LexisNexis, 701 E. Water Street, Charlottesville, VA 22902-5389.

August 2011 LexisNexis

# User's Guide

This guide is designed to help both the lawyer and the layperson get the most out of the Mississippi Code of 1972 Annotated. Information about key features of the Code and suggestions for its more effective use are given under the following headings:

— Advance Code Service
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— Attorney General Opinions
— Code Status
— Comparable Legislation from other States
— Court Rules
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— Research and Practice References
— Source Notes
— Statute Headings
— Tables

If you have a question not addressed by the User's Guide, or comments about your Code service, you may contact us by calling us toll-free at (800) 833-9844, faxing us toll-free at (800) 643-1280, e-mailing us at customer.support@bender.com, or writing to Mississippi Code Editor, LexisNexis, 701 E Water Street, Charlottesville, VA 22902-5389.

## ADVANCE CODE SERVICE

Three times a year, at roughly quarterly intervals between delivery of Code supplement pocket parts, we publish the Mississippi Advance Code Service pamphlets. These pamphlets contain updated statutory material and annotations to Attorney General opinions, research and practice references, and recent court decisions construing the Code. Each pamphlet is cumulative, so that each is a "one-stop" source of case notes updating those in your Code bound volumes and pocket parts.

## ADVANCE SHEETS

The Advance Sheets consist of a series of pamphlets issued in the spring. The series reproduces the acts passed by the Mississippi Legislature and approved by the Governor during the legislative session. Features include tables showing the impact of legislation on sections of the Mississippi Code of 1972 Annotated, and a cumulative index. These pamphlets enable the user to receive a preview of approved legislation prior to supplement availability, and serve as an excellent source of legislative history.

## AMENDMENT NOTES

Every time a Code provision is amended, we prepare a note describing the effect of the amendment. By reading the note, you can ascertain the impact of the change without having to check the former statute itself.

Amendment notes are retained in the Supplement until the bound volume is replaced, at which time notes from all but the last two years are deleted.

Amendment notes are available online from 1991 until the present in the Mississippi Legislative Archive.

## ANALYSES

Each title, chapter, and article appearing in a bound volume or supplement is preceded by an analysis. The analysis details the scope of the title, chapter, and article and enables you to see at a glance the content of the title, chapter, and article without resorting to a page-by-page examination in the bound volume or supplement.

## ATTORNEY GENERAL OPINIONS

Opinions of the Attorney General for the State of Mississippi have been read for constructions of Mississippi law. Notes describing the subject matter of the opinions have been placed under relevant Code provisions under the heading "Attorney General Opinions." The citation at the end of each note refers to the person requesting the opinion, the date of the opinion, and the opinion number.

## CODE STATUS

The Mississippi Code of 1972 Annotated is Mississippi's official code and is considered evidence of the statute law of the State of Mississippi (see § 1-1-8). The Code was enacted by Chapter 394 of the Laws of 1972, which was signed by the Governor on April 26, 1972.

Title 1, Chapters 1 through 5 of the Code contain statutes governing the status and construction of the Code.

## COMPARABLE LEGISLATION FROM OTHER STATES

Notes to comparable legislation from other states appear for uniform laws, interstate compacts, statutory provisions pertaining to reciprocity and cooperation with other states, and various important statutes of general interest. Other states' statutes that are similar in subject matter and scope to those of Mississippi are cited, generally, under the first section of the chapter or article to which they pertain. Occasionally, comparable legislation pertains to only one section, in which case it is cited under that section rather than at the chapter or article level.

See also *Federal Aspects.*

## COURT RULES

The Mississippi Court Rules are published separately by LexisNexis in a fully annotated softcover volume which is replaced annually and supplemented semi-annually.

The Court Rules volume contains statewide rules of procedure of the state courts, the local rules of the United States district courts and bankruptcy courts for Mississippi, and the rules of the United States Court of Appeals for the Fifth Circuit. Rules are received from the courts and edited only for stylistic consistency. For further information, see the Preface to the Mississippi Court Rules volume.

## CROSS REFERENCES

Cross references refer you to notes under other Code sections, that may affect a law or place it in context. Cross references also are used under repealed provisions to refer you to an existing law on a similar subject. Cross references do not cite all related statutes, however, since these can be identified by using the General Index.

See also *Comparable Legislation from other States* and *Federal Aspects.*

## EDITOR'S NOTES

Editor's notes are notes prepared by the Publisher that contain information about important or unusual features of a law, or special circumstances surrounding passage of the law, that are not apparent from the law's text.

See also *Effective Dates.*

## EFFECTIVE DATES

Absent a specific effective date provision within an act, Mississippi laws generally take effect upon approval date, which is the date the act is signed into law by the Governor. Acts affecting voting rights and procedures take effect on the date the United States Attorney General interposes no objection under § 5 of the Voting Right Act of 1965.

## FEDERAL ASPECTS

Notes to federal legislation that is similar in subject matter and scope to the laws of Mississippi are referenced throughout the Code. In addition, the Code contains the United States Code Service citation for any federal law that is referred to in a Mississippi statute by its popular name or by its session law designation.

See also *Comparable Legislation from other States.*

## INDEX

The Code is completely indexed in two softcover Index volumes, which are updated and replaced annually. In addition, each volume of the Code is followed by its own index. As accurate and thorough as the Index is, your best defense against index wild goose chases is familiarity with indexing techniques. To that end, an explanatory Foreword to the Index appears in the first Index volume.

## JOINT LEGISLATIVE COMMITTEE NOTES

Joint Legislative Committee notes are included in the Code to describe codification decisions made by the Mississippi Joint Legislative Committee on Compilation, Revision and Publication of Legislation. Examples of Committee actions that warrant the inclusion of a note are the integration of multiple amendments to a single Code section during the same legislative session, and the correction of typographical errors appearing in the Code.

## JUDICIAL DECISIONS

Every reported case from the Supreme Court of Mississippi, the Court of Appeals of Mississippi, federal district courts for Mississippi, the federal Fifth Circuit Court of Appeals and the United States Supreme Court has been read for constructions of Mississippi law. These constructions are noted under pertinent sections of the statutes or Mississippi Constitution provisions, under the heading "Judicial Decisions." Where a decision has been reviewed by a higher court, subsequent judicial history and disposition is noted in the case note if such disposition has any bearing on the annotated material. Where two or more decisions state the same rule of law, the case citations are cumulated under one case note.

Case notes are grouped together under headings called "catchlines." The catchlines identify the basic subject matter of the case notes and assist the user in locating pertinent notes. Catchlines are numbered and arranged thematically, with "In general" first. Where there are two or more catchlines, an analysis, listing all the catchlines, precedes the annotations.

Frequently, statutes carry notes to cases that arose under earlier laws on the same subject. Case notes are retained so long as the editor believes the note will have some relevance under current law, though of course the relevance may be diminished by later changes in the law. These case notes appear under the heading “Decisions under former law.”

## ORGANIZATION AND NUMBERING SYSTEM

The Code is organized by titles, chapters, articles, subarticles, undesignated centered headings and sections. Analyses at the beginning of each title, chapter, article, and subarticle help you understand the internal arrangement of each Code unit (see *Analyses*).

Odd numbers are generally used for the numbering of titles, chapters and sections. Even numbers have been used for some chapters and sections so that a particular new chapter or section might be logically placed with other chapters and sections dealing with the same or similar subject matter. Similarly, the use of numbers with decimal points has been used for some sections in order that they may be inserted among other sections pertaining to the same subject.

The title, chapter, and section for each Code section is revealed by its section number. Thus, in the designation “§ 1-3-65,” the first digit (“1”) means the provision is in Title 1 (“Laws and Statutes”); the second (“3”) indicates Chapter 3 (“Construction of Statutes”); and the last two digits (“65”) mean the 65th section in that chapter (“Construction of terms generally”).

Articles and subarticles are not reflected by section number designations.

Within sections, subsections and paragraphs usually are designated following this pattern: (1)(a)(i)1. or (1)(a)(i)A. A distinctive indention scheme is applied to suggest the relative value of each unit within this hierarchy.

## PLACEMENT OF NOTES

Where a note pertains to a single statute section, it will of course be set out following that section. In many instances, however, a note applies equally to several statute sections or to an entire chapter or article. If the pertinent sections are scattered, or few in number, the note will be duplicated for each section. But where the note applies to all or most of the sections in a chapter or article, we prevent the space-consuming repetition of notes by placing the note at the very beginning of the chapter or article.

## REPLACEMENT VOLUMES

The Code is periodically updated and streamlined by the replacement of volumes. Although a current set of the Code contains all currently applicable statutes, we encourage you to retain replaced volumes and their supplement pockets parts for historical reference.

## RESEARCH AND PRACTICE REFERENCES

Citations to references in American Jurisprudence, American Jurisprudence Pleading and Practice, American Jurisprudence Proof of Facts, American Jurisprudence Trials, American Law Reports, First through Sixth Series, ALR Federal, Corpus Juris Secundum, various other treatises and practice guides, and Mississippi law journals are given under this heading, wherever the references appear to discuss the statute under which the citation appears, or a topic related to the statute. These citations are intended only to give you a starting point for your library research. The Mississippi law journals include Mississippi Law Journal and Mississippi College Law Review.

## SOURCE NOTES

Each section of the Code is followed by a brief note showing the acts of the legislature on which it is based, including the act that originally enacted the section and any subsequent amendments.

The source note follows the section text, preceding any other annotations for the section. Information in the source note is listed in chronological order, with the most recent information listed last. If a section has been renumbered, the former number will appear in the source note. :

The tables volume should also be consulted when researching the history of a statutory section, since it contains cross reference tables that provide a statutory citation for each section of the session laws and the date each act went into effect.

## STATUTE HEADINGS

Headings or "catchlines" for Code sections and subsections are generally created and maintained by the publisher. They are mere catchwords and are not to be deemed or taken as the official title of a section or as a part of the section. Your suggestions for the improvement of particular catchlines are invited.

## TABLES

The Mississippi Code of 1972 Annotated contains several tables that can assist you in your research. These are published in the Statutory Tables volume of the Code, and include the following:

- Sections of the Code of 1930 carried into the Code of 1942.
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- Allocation of Acts of Legislature, 1931 — 1972.
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## § 83-21-1. Certificate of authority.

No foreign insurance, indemnity or guaranty company or other insurer shall be admitted and authorized to do business in this state until:

(a) It shall deposit with the Commissioner of Insurance a certified copy of its charter, articles of incorporation, bylaws or deed of settlement, and shall pay for the filing of such document the sum of One Thousand Dollars ($1,000.00) and a statement of its financial condition and business in such form and detail as he may require, signed and sworn to by its president and secretary or other proper officer.

(b) It shall satisfy the commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact; and such capital or net assets are well invested and immediately available for the payment of losses in this state, and that it insures on any single hazard a sum no larger than one-tenth (1/10) of its net assets.

(c) It shall, by a duly executed instrument filed in his office, constitute and appoint the Commissioner of Insurance, and his successor, its true and lawful attorney, upon whom all process in any action or legal proceeding against it may be served, and therein shall agree that any process against it which may be served upon its attorney shall be of the same force and validity as if served on the company, and the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state. The service of such process shall be made by leaving a copy of the same in the hands or office of the commissioner. Copies of such instrument certified by the commissioner shall be deemed sufficient evidence thereof, and service upon such attorney shall be deemed sufficient service upon the principal.

(d) It shall appoint as its agent or agents in this state some resident or residents thereof, other than the commissioner; such appointment to be made in writing, signed by the president and secretary or manager or general agent, and filed in the office of the commissioner, authorizing the agent to acknowledge service of process for and on behalf of the company, consenting that service of process on the agent shall be as valid as if served upon the company, according to the laws of this state, and waiving all claims of error by reason of such service.

(e) It shall obtain from the commissioner a certificate that it has complied with the laws of the state and is authorized to make contracts of insurance.

(f) Such fees collected by the commissioner shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

**SOURCES: Codes, 1906, § 2606; Hemingway's 1917, § 5069; 1930, § 5165; 1942, § 5672; Laws, 1977, ch. 326; Laws, 1977, ch. 395; Laws, 1982, ch. 391, § 1; Laws, 1988, ch. 526, § 7; Laws, 1991, ch. 429 § 1; Laws, 2003, ch. 347, § 1, eff from and after July 1, 2003.**

**Editor's Note —** Section 13 of ch. 526, Laws of 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

**Cross References —** Treatment, for income tax purposes, of interest earned by foreign insurance companies from loans secured by real estate in Mississippi, see § 27-7-23.

Mississippi insurance premium tax retaliatory law, see §§ 27-15-121 et seq.

Duty of commissioner before admitting foreign company, see § 83-1-23.

Examination of financial condition of foreign insurance company, see § 83-1-27.

Notification of foreign company of service of process upon commissioner, see § 83-5-11.

Regulation of sale of stock, see § 83-5-19.

Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Merger or consolidation, or exchange of outstanding stock, of domestic and foreign stock insurance companies, see § 83-19-113.

For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

Laws applicable to admitted foreign company, see § 83-21-7.

Admission of foreign fraternal society, see §§ 83-29-29 et seq.

Admission of foreign mutual company, see § 83-31-39.

Admission of foreign burial association, see § 83-37-7.

Legal expense insurance, see §§ 83-49-1 et seq.

Application of venue provisions of §§ 83-21-1 et seq. to legal expense insurance plan sponsors, see § 83-49-33.

For the rule controlling service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

## JUDICIAL DECISIONS

1. In general.
2. Appointment of insurance commissioner as attorney to receive service of process.
3. Appointment of agent upon whom process may be served.

**1. In general.**

Commissioner of Insurance is a statutory agent, rather than an agent in fact, under Miss. Code Ann. § 83-21-1(c) because foreign insurers are required to appoint the Commissioner as an agent; the linchpin for distinguishing agents in fact from statutory agents is not whether a statute requires the appointment, but whether the statute compels the appointment of a certain person, and an agent appointed under § 83-21-1(d) is an agent in fact because an insurer can choose the agent's identity. Burton v. Cont'l Cas. Co., — F. Supp. 2d —, 2006 U.S. Dist. LEXIS 79299 (S.D. Miss. Oct. 30, 2006).

Testimony of deputy chancery clerk that he had received statement from auditor held not proper proof of filing of charter, bylaws, rules, and regulations by the company. Supreme Ruling of Fraternal Mystic Circle v. Turner, 105 Miss. 468, 62 So. 497 (1913).

Statutes liberally construed so as to include all organizations doing an insurance business of any kind. State v. Alley, 96 Miss. 720, 51 So. 467 (1910).

**2. Appointment of insurance commissioner as attorney to receive service of process.**

Plaintiff's motion for reconsideration of an order denying his motion to remand to state court his suit against an insurer was denied; 28 U.S.C.S. § 1446's 30-day removal period did not begin running until the state insurance commissioner, who was a statutory agent that the insurer was required to appoint under Miss. Code Ann. § 83-21-1(c), gave the insurer a copy of the summons and complaint that had been served upon the commissioner, and because the insurer sought removal 29 days after receiving that notice, the motion to remove was timely. Burton v. Cont'l Cas. Co., — F. Supp. 2d —, 2006 U.S. Dist. LEXIS 79299 (S.D. Miss. Oct. 30, 2006).

In action by a buyer against a foreign insurer for damages for the value of an automobile and for the loss of its use, process issued by the circuit court clerk and served by the sheriff upon the insurance commissioner was insufficient to support a default judgment where the record failed to show that a certified copy of an instrument appointing the insurance commissioner as the insurer's true and lawful attorney was filed in the case. Motors Ins. Corp. v. Holland, 229 Miss. 262, 90 So. 2d 392 (1956).

A statute calling for a foreign corporation residing outside the state to designate a person within the state as its agent for service of process in the state in return for the privilege of doing business within the state, is constitutional, and the designation of such agent is a voluntary act by which the corporation consents to be sued in the state; and such consent, when executed in conformity with valid state statute, extends to any court sitting in the state which applies the laws of the state, including federal courts, and therefore constitutes consent to be sued in federal court in the state and supplants the immunity conferred by rules governing venue. Neirbo Co. v. Bethlehem Shipbuilding Corp., 308 U.S. 165, 60 S. Ct. 153, 84 L. Ed. 167, 128 A.L.R. 1437 (1939).

The authorization by a foreign insurance company, conformably to this statute, of the state insurance commissioner as its attorney upon whom process may be served, which states that such authority may continue "so long as any liability of the company remains outstanding" in the state, does not extend to the acceptance of service of process in a suit brought by a nonresident upon a cause of action not arising in the state. Morris & Co. v. Skandinavia Ins. Co., 279 U.S. 405, 49 S. Ct. 360, 73 L. Ed. 762 (1929).

If declaration against foreign indemnity company was required to set out appointment by company of insurance commissioner of state as company's process agent, such fact was sufficiently alleged in declaration which set out that foreign company was qualified to do business in state and "subject to the process of this court by service of summons" on insurance commissioner of Mississippi. Rawlings v. AMOCO, 173 Miss. 683, 161 So. 851 (1935).

In garnishment proceeding against bank's receiver by judgment creditor of foreign indemnity company, it would be conclusively presumed that court rendering judgment had before it necessary proof of appointment of state insurance commissioner as company's process agent, where judgment recited that defendants were legally served with personal process, and return on process in record showed service on insurance commissioner as process agent for company. Rawlings v. AMOCO, 173 Miss. 683, 161 So. 851 (1935).

Certified copy of appointment of state insurance commissioner as agent for foreign insurance corporation for service of process held sufficient proof of such fact as basis for service of writ of garnishment. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817 (1934).

Word "liability," within statute authorizing appointment of state insurance commissioner as agent of foreign insurance corporation for service of process, held not confined to contracts along, but to any liability cognizable in courts. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817 (1934).

Appointment of state insurance commissioner as agent of foreign insurance corporation for service of process cannot be revoked as long as there is any outstanding liability against insurance corporation in state. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817 (1934).

Statute requiring foreign insurance companies to appoint insurance commissioner as agent for service of process does not subject such insurance companies to jurisdiction of state courts in controversies growing out of transactions wholly without state. Morris & Co. v. Skandinavia Ins. Co., 161 Miss. 411, 137 So. 110 (1931).

The authorization by a foreign insurance company, conformably to this statute, of the state insurance commissioner as its attorney upon whom process may be served, which states that such authority may continue "so long as any liability of the company remains outstanding" in the state, does not extend to the acceptance of service of process in a suit brought by a nonresident upon a cause of action not arising in the state. Morris & Co. v. Skandinavia Ins. Co., 279 U.S. 405, 49 S. Ct. 360, 73 L. Ed. 762 (1929).

Mere showing of service of summons on state insurance commissioner held insufficient to authorize default judgment against foreign insurance company. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125 (1914); Continental Cas. Co. v. Gilmer, 146 Miss. 22, 111 So. 741 (1927).

Clerk need not mail copy of summons to foreign insurance company where insurance commissioner was served as its attorney in fact. Fidelity & Cas. Co. v. Cross, 127 Miss. 31, 89 So. 780 (1921).

Court cannot take judicial notice of appointment of insurance commissioner as agent for process by his acceptance of service. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125 (1914).

Appointment of insurance commissioner as agent for service of process can be proved only by certified copy thereof. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125 (1914).

**3. Appointment of agent upon whom process may be served.**

Jurisdiction of foreign insurance company cannot be obtained by service on former agent who is not in fact agent of company when process is served. Fireman's Fund Ins. Co. v. Cole, 169 Miss. 634, 152 So. 872 (1934).

Statute providing for substituted service on foreign corporation does not apply to suits against insurance companies appointing agents for service of process. Great S. Life Ins. Co. v. Gomillion, 145 Miss. 314, 110 So. 770 (1927).

Return of process served on duly appointed agent of insurance company may be amended during next sitting term without service of copy of motion to amend. Great S. Life Ins. Co. v. Gomillion, 145 Miss. 314, 110 So. 770 (1927).

### RESEARCH REFERENCES

**Practice References.** Thomas, Jeffrey E., Martinez, Leo P., Mayerson, Marc S., and Richmond, Douglas R., 2011 Edition of New Appleman Insurance Law Practice Guide.

**ALR.** Theory of waiver as applicable where provisions of policy or acts of insurer are inconsistent with statutory requirements. 9 A.L.R.2d 1436.

Construction, application, and operation of state "retaliatory" statutes imposing special taxes or fees on foreign insurers doing business with the state. 30 A.L.R.4th 873.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 85, 86.

14 Am. Jur. Pl & Forms (Rev), Insurance, Form No. 22 (petition or application for writ of mandamus to compel issuance of license to foreign corporation to conduct insurance business within state).

**CJS.** 44 C.J.S., Insurance §§ 129, 130.

## § 83-21-3. Requirements for admission.

(1) No foreign insurance company, association, or other insurance entity, either stock, mutual, or reciprocal, shall be admitted to do business or granted a certificate of authority or license to do business in this state unless and until such company or association shall have done business for a period of at least two (2) years in the state of its domicile, or unless such company seeking admission is the subsidiary or affiliate of a company already licensed in Mississippi.

(2) No foreign stock insurance company shall be admitted or granted a certificate of authority or license to do business in this state unless its paid-up capital stock and its surplus at the time of licensing or renewal of license shall be equal to that required for the organization or incorporation of a like domestic company under the laws of this state.

(3) No foreign mutual or reciprocal insurance company or association shall be admitted or granted a certificate of authority or license to do business

in this state unless, at the time of licensing or renewal of license, its surplus shall be equal to that required by the laws of this state for the organization or formation of a like domestic insurance company or association.

(4) No foreign stock, mutual, or reciprocal insurance company or association, incorporated or organized under the laws of any state of the United States, shall be admitted to do business, or granted a certificate of authority, or have license therefor renewed until such company shall have deposited with the State Treasurer of this state securities in an amount not less than Fifty Thousand Dollars ($50,000.00). Securities deposited in accordance with this section shall be classified as admitted assets for the purpose of determining eligibility of such securities. Provided, however, any company maintaining a deposit with the insurance regulatory authority or any other designated public official of its state of domicile, or of any other state, in trust for the benefit of all its policyholders, or policyholders and creditors, may be exempt from the deposit herein provided upon such company delivering to the Insurance Commissioner a certificate to such effect, duly authenticated by the appropriate state official holding such deposit. The commissioner may require in addition to the certification of deposit by the public official of its state of domicile an amount not less than Fifty Thousand Dollars ($50,000.00) be deposited with the State Treasurer of this state. Any deposit made in this state under the provisions of this section shall be for the exclusive use and benefit of policyholders, or policyholders and creditors, in this state; and such deposit shall not bar claim to other assets of the company by policyholders, or policyholders and creditors, in this state in the event of insolvency, receivership, or liquidation of the company.

Notwithstanding any other provision of law, the securities eligible for deposit under the insurance laws of this state relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the Insurance Commissioner and shall not be withdrawn by the insurance company without the approval of the Insurance Commissioner. Any insurance company holding securities in such manner shall provide to the Insurance Commissioner evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the Insurance Commissioner.

(5) In case any insurer which has made a deposit with the Commissioner of Insurance, or other designated official or custodian in this state, of cash or securities in trust for the protection of its policyholders or creditors or both in

this state, or of its policyholders or creditors or both in the United States, thereafter becomes merged or consolidated in accordance with the laws of this state if a domestic insurer, or in accordance with the laws of its domiciliary state or nation if a foreign or alien insurer, and upon the effectuation of the merger or consolidation, the resulting corporation is or becomes authorized to do business in this state, the commissioner, or other designated official or custodian, as the case may be, upon the resulting corporation's being so authorized, shall release and transfer the cash or securities so deposited by the merged or consolidated insurer to the resulting corporation, or to such person as it may designate to take and receive the same.

If any insurer which has made such a deposit with the Commissioner of Insurance or other designated official or custodian in the state hereafter withdraws from and ceases to do business in this state, and has paid or provided for the payment of all its obligations and liabilities to its policyholders and creditors in this state by the assumption or reinsurance of the same by an insurer which is or becomes authorized to transact business in this state, the Commissioner of Insurance or other designated official or custodian, as the case may be, shall release and transfer the cash or securities constituting its deposit to such withdrawing insurer, or to such person as it may designate to take and receive the same.

Any release or transfer pursuant hereto shall be made upon application to and the written order of the Commissioner of Insurance. Neither the Commissioner of Insurance, nor other designated official or custodian, as the case may be, shall have any liability for the release or transfer of any such deposit made or authorized in good faith.

**SOURCES: Codes, 1942, § 5677.5; Laws, 1956, ch. 333, §§ 1-3; Laws, 1958, ch. 442, § 1; Laws, 1962, ch. 462, § 1; Laws, 1991, ch. 420 § 1; Laws, 2001, ch. 412, § 6, eff from and after July 1, 2001.**

**Cross References** — Acceptability of farm credit securities for deposit, see § 75-69-7.

Provisions relating to paid-up capital stock and surplus requirements for domestic stock insurance companies, see § 83-19-31.

For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

Revocation of license for deficiency in capital, surplus, or reserves, see § 83-21-13.

Surety companies to possess capital and surplus requirements as required in this section and § 83-19-31, see § 83-27-1.

Utilization of modern systems such as clearing corporations and the Federal Reserve book-entry system for the deposit of securities without physical delivery, see §§ 83-67-1 et seq.

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 85, 86.

**CJS.** 44 C.J.S., Insurance §§ 132, 133.

## § 83-21-5. Deposit required for companies outside United States.

No foreign company, if incorporated or organized under the laws of any government or state elsewhere than in the United States, shall be admitted until it has made a deposit with the treasurer of the state, or with the financial officer of some other states of the United States, of a sum not less than the capital required of like companies under this chapter. Such deposit must be in exclusive trust for the benefit and security of all the company's policyholders and creditors in the United States, and such deposit shall be deemed for all purposes of the insurance law the capital of the company making it.

**SOURCES: Codes, 1906, § 2610; Hemingway's 1917, § 5073; 1930, § 5166; 1942, § 5676.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 85.

**CJS.** 44 C.J.S., Insurance §§ 132, 133.

## § 83-21-7. Applicable laws.

Foreign insurance companies, upon complying with the conditions applicable to such companies, may be admitted to transact in this state, by constituted agents resident therein, any class of insurance authorized by the laws now or hereafter in force relative to the duties, obligations, prohibitions, and penalties of insurance companies, and shall be subject to all laws applicable to the transaction of such business by foreign insurance companies and their agents. No provision of law which by its terms applies specifically to domestic life insurance companies shall thereby become applicable to foreign life insurance companies; and in the case of life insurance companies, the residence requirement shall not apply to agents who are residents of other states which permit residents of Mississippi to be licensed therein.

**SOURCES: Codes, 1892, § 2340; 1906, § 2605; Hemingway's 1917, § 5068; 1930, § 5167; 1942, § 5677; Laws, 1928, ch. 23.**

**Cross References —** Laws applicable to domestic insurance companies, see § 83-5-13.

Laws applicable to nonadmitted insurer, see § 83-21-17.

Laws applicable to mutual companies, see § 83-31-37.

### JUDICIAL DECISIONS

**1. In general.**

Under the 14th amendment of the Federal Constitution, a foreign insurance company which has not complied with the laws prescribing how such companies may do business in this state cannot be denied the right to sue in the courts of this state to collect premium on a policy written in the state of the company's domicile. Swing v. B.E. Brister & Co., 87 Miss. 516, 40 So. 146 (1906).

Policy of insurance on property in this state written through a broker of another state in a foreign company was not a Mississippi contract, and not void because the insurer had not complied with the laws of this state. Swing v. B.E. Brister & Co., 87 Miss. 516, 40 So. 146 (1906).

Suit to collect premiums on such policies is not transacting the business of insurance in this state. Swing v. B.E. Brister & Co., 87 Miss. 516, 40 So. 146 (1906).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 79 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 41 (complaint or declaration by state against foreign insurance company for forfeiture of licenses-formation of monopoly through underwriters' association).

**CJS.** 44 C.J.S., Insurance § 127.

## § 83-21-9. License refused on certain conditions.

When an insurance company organized under the laws of any state or country is prohibited by the laws of said state or country or by its charter from investing its assets other than capital stock in the bonds of this state, then and in such case the commissioner of insurance is authorized and directed to refuse to grant a license to transact business in Mississippi to such insurance company.

**SOURCES: Codes, 1906, § 2617; Hemingway's 1917, § 5080; 1930, § 5168; 1942, § 5678.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 85.

**CJS.** 44 C.J.S., Insurance §§ 129, 130.

## § 83-21-11. Repealed.

Repealed by Laws, 1997, ch. 410, § 25, eff from and after July 1, 1997.

[Codes, 1906, § 2667; Hemingway's 1917, § 5133; 1930, § 5169; 1942, § 5679]

**Editor's Note** — Former § 83-21-11 provided for the revocation of insurance licenses of foreign insurance companies under certain conditions.

## § 83-21-13. Revocation of license for deficiency in capital, surplus, or reserves.

Any company heretofore licensed shall have its financial status reviewed upon the filing of its annual statement, and in the event of a deficiency in either capital, surplus, or reserves, the license of the company and the certificate of authority of its agents to represent said company shall be immediately revoked.

**SOURCES: Codes, 1942, § 5679.5; Laws, 1958, ch. 442, § 2.**

**Cross References —** Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

Capital and surplus requirements for admission, see § 83-21-3.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 87.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance §§ 129, 130.

## § 83-21-15. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

[Codes, 1942, § 5674; Laws, 1942, ch. 271; Laws, 1948, ch. 347; Laws, 1956, ch. 338, §§ 1-10; Laws, 1994, ch. 385, § 1; Laws, 1995, ch. 361, § 2; Laws, 1996, ch. 319, § 1; Laws, 1999, ch. 345, § 1; Laws, 2001, ch. 376, § 1.]

**Editor's Note —** Former § 83-21-15 was entitled "Non-resident brokers or agents."

## § 83-21-17. Nonadmitted insurers.

(1) The Commissioner of Insurance shall annually promulgate a list of nonadmitted insurers found eligible for writing business in the State of Mississippi, provided each such insurer qualifies under one (1) of the following paragraphs:

(a) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which is the greater of:

(i) The same requirements as to capital and surplus as is required of a company licensed to do business in the State of Mississippi; or

(ii) Fifteen Million Dollars ($15,000,000.00).

(b) The requirements of paragraph (a) of this subsection may be satisfied by an insurer's possessing of less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than Four Million Five Hundred Thousand Dollars ($4,500,000.00).

(c) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both incorporated and unincorporated insurers:

(i) The plan or group maintains a trust fund that shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States;

(ii) In addition, the group shall establish and maintain in trust a surplus in the amount of One Hundred Million Dollars ($100,000,000.00), which shall be available for the benefit of United States surplus lines policyholders of any member of the group;

(iii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and

(iv) The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, the trust required by subparagraph (ii) of this paragraph shall satisfy the requirements of the Standard Trust Agreement required for listing with the National Association of Insurance Commissioners' (NAIC) International Insurers Department.

(d) In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to this time, and which submits to this state's authority to examine its books and records and bears the expense of the examination:

(i) The group shall maintain an aggregate policyholders' surplus of Ten Billion Dollars ($10,000,000,000.00); and

(ii) The group shall maintain in trust a surplus in the amount of One Hundred Million Dollars ($100,000,000.00), which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and

(iii) Each insurer shall individually maintain capital and surplus of not less than Twenty-five Million Dollars ($25,000,000.00) per company; and

(iv) The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the NAIC's International Insurers Department, and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state; and

(v) Additionally, each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

(e) Except for a plan complying with paragraphs (c) or (d) of this subsection, an insurer not domiciled in one (1) of the United States or its territories shall satisfy the capital and surplus requirements of paragraph (a) and shall have in force a trust fund of not less than the greater of:

(i) Five Million Four Hundred Thousand Dollars ($5,400,000.00); or

(ii) Thirty percent (30%) of the United States surplus lines gross liabilities, excluding aviation, wet marine and transportation insurance liabilities, not to exceed Sixty Million Dollars ($60,000,000.00) to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December 31 next preceding the date of determination, where:

1. The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of United States policyholders consisting of cash, securities, letters of credit or other investments of substantially the same character and quality as those which are eligible investments under Section 83-19-51 for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall satisfy the requirements of the Standard Trust Agreement required for listing with the NAIC's International Insurers Department; and

2. The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims; provided, however, that the balance of the trust fund is never less than the greater of Five Million Four Hundred Thousand Dollars ($5,400,000.00) or thirty percent (30%) of the insurer's current gross United States surplus lines liabilities, excluding aviation, wet marine and transportation insurance liabilities; and

3. In calculating the trust fund amount required by this subsection, credit shall be given for surplus lines deposits separately required and maintained for a particular state or United States territory, not to exceed the amount of the insurer's loss and loss adjustment reserves in the particular state or territory.

(f) An insurer or group of insurers meeting the requirements to do a surplus lines business in this state on March 11, 2011, shall have two (2) years from March 11, 2011, to meet the requirements of paragraph (e) of this subsection as follows:

| **Year Following March 11, 2011** | **Trust Fund Requirement** |
|---|---|
| 1 | Fifteen percent (15%) of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of Thirty Million Dollars |
| 2 | Thirty percent (30%) of U.S. surplus lines liabilities, excluding aviation, wet marine |

and transportation insurance,
with a maximum of Sixty
Million Dollars
($60,000,000.00)

(g) The commissioner shall have the authority to adjust, in response to inflation, the trust fund amounts required by paragraph (e) of this subsection.

(h) An alien insurer shall be listed with the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

(2) The Commissioner of Insurance is specifically vested with authority to promulgate such rules and regulations as deemed necessary to carry out the provisions hereof.

(3) The commissioner shall publish a list of nonadmitted insurers found eligible for writing business in the State of Mississippi on a nonadmitted basis. The commissioner may, by giving seven (7) days' notice, at any time remove a nonadmitted insurer from such eligible list when it appears that such insurer no longer meets the requirements of the statute or regulations of the commissioner. When a nonadmitted insurer is placed upon or removed from the eligible list, all surplus lines insurance producers holding licenses under Sections 83-21-17 through 83-21-31 shall be notified of such eligibility or removal.

(4) Each nonadmitted insurer shall annually pay a filing fee of Five Hundred Dollars ($500.00) in order to be eligible for certification as a nonadmitted insurer.

(5)(a) Each insured in this state who directly procures or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed, in whole or in part, in this state, other than insurance procured through a surplus lines licensee, shall, within thirty (30) days after the date the insurance was so procured or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner.

(b) Gross premiums charged for the independently procured insurance, less any return premiums, are subject to the same premium tax rate as set forth in Section 83-21-25. At the time of filing the report required in paragraph (a) of this subsection (5), the insured shall pay the tax to the commissioner.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1988, ch. 526, § 8; Laws, 1991, ch. 353 § 1; Laws, 1994, ch. 333, § 2; Laws, 2011, ch. 380, § 1, eff from and after passage (approved Mar. 11, 2011.)**

**Editor's Note** — Laws of 1988, ch. 526, § 13, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now Section 25-43-1.101 et seq.], Mississippi Code of 1972."

**Amendment Notes** — The 2011 amendment rewrote the section.

**Cross References** — Revocation of license of fire and casualty insurance agents, see § 83-17-13.

Capital and surplus requirements for admission, see § 83-21-3.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

## JUDICIAL DECISIONS

**1. In general.**

A nonadmitted insurer was not liable to its former insured where the insurer had required that reinstatement of lapsed insurance policies could only be made by payment of the premiums to it at its home office in Alabama but the former insured had instead made payments of the premiums to a local, Mississippi insurance agent. Pasco Enters., Inc. v. Southland Ins. Agency, Inc., 408 So. 2d 63 (Miss. 1981).

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 80.

**CJS.** 44 C.J.S., Insurance § 125.

## § 83-21-18. Agreements with other states to establish procedures for allocation of premium taxes; definitions.

(1) The Commissioner of Insurance may enter into an agreement, compact, or otherwise establish procedures to allocate among the states the premium taxes paid to an insured's home state according to the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), which was incorporated intact into the Dodd-Frank Financial Reform Bill, H.R. 4173, which provides that only an insured's "home state" may require a premium tax payment for nonadmitted insurance, and that the placement of all nonadmitted insurance shall be subject solely to the statutory and regulatory requirements imposed by the insured's "home state."

(a) The agreement, compact, or procedures may provide for the adoption of nationwide uniform requirements, forms and procedures which provide for the reporting, payment, collection and allocation of premium taxes for nonadmitted insurance consistent with the NRRA.

(b) This agreement may allow the commissioner to collect and disburse to reciprocal states any funds collected under a policy that may be allocated to another reciprocal state where the insurance covers properties, risks or exposures located or to be performed both in and out of this state. The sum payable may include the amount of gross premiums and fees allocated to this state, plus an amount equal to the portion of premium and fees allocated to other states or territories, on the basis of the tax rates and fees applicable to properties, risks or exposures located or to be performed outside of this state. To the extent that other states where portions of the properties, risks or exposures reside have failed to enter into a compact or reciprocal allocation procedures with this state, the net premium tax may be retained by this state.

(c) The commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(2) For the purposes of this chapter, the following definitions shall apply:

(a) "Home state" means:

(i) In general, except as provided in subparagraph (ii), the term "home state" means, with respect to an insured:

1. The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

2. If one hundred percent (100%) of the insured risk is located outside the state referred to in item 1 of this subparagraph (i), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(ii) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined according to subparagraph (i)1 of this paragraph (a), of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(b) "Independently procured insurance" means any property and casualty insurance permitted in a state to be placed directly with a nonadmitted insurer eligible to accept such business.

(c) "Multistate risk" means a risk covered by a nonadmitted insurer with insured exposures in more than one (1) state.

(d) "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly or through a surplus lines insurance producer with a nonadmitted insurer eligible to accept such insurance.

(e) "Principal place of business" means, with respect to determining the home state of the insured, the state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business activities.

(f) "Principal residence" means, with respect to determining the home state of the individual, the state where the individual resides for the greatest number of days during a calendar year.

(g) "Single-state risk" means a risk covered by a nonadmitted insurer with insured exposures in only one (1) state.

(h) "Surplus lines insurance" means any property and casualty insurance permitted in a state to be placed through a surplus lines insurance producer with a nonadmitted insurer eligible to accept such insurance.

(i) "Surplus lines insurance producer" means an individual who is licensed in this state to sell, solicit or negotiate insurance on properties, risks or exposures located or to be performed in this state with nonadmitted insurers.

(3) The provisions set forth in Sections 83-21-19 through 83-21-27 shall only apply if Mississippi is the home state as defined herein.

**SOURCES: Laws, 2011, ch. 380, § 2, eff from and after passage (approved Mar. 11, 2011).**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in (2)(a)(ii). The word "has" was inserted between the words "that" and "the" in following excerpt "...a member of the affiliated group that the largest percentage..." so the phrase now reads "a member of the affiliated group that has the largest percentage..." The Joint Committee ratified the correction at its July 13, 2011, meeting.

**Federal Aspects —** Nonadmiteed and Reinsurance Reform Act of 2010, see 15 USCS § 8201 et seq.

Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, 124 Stat. 1376.

## § 83-21-19. Resident and nonresident surplus lines insurance producers; licensing; fees; suspension, revocation or refusal of license; grounds; notice; hearing.

(1) Surplus lines insurance may be placed by a surplus lines insurance producer if:

(a) Each insurer is an eligible surplus lines insurer; and

(b) Each insurer is authorized to write the line of insurance in its domiciliary jurisdiction; and

(c) The full amount or type of insurance cannot be obtained from insurers who are admitted to do business in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state, if any are writing it; and

(d) All other requirements as set forth by law are met.

(2) The Commissioner of Insurance, upon the biennial payment of a fee of One Hundred Dollars ($100.00) and submission of a completed license application on a form approved by the commissioner, may issue a surplus lines insurance producer license to a qualified holder of an insurance producer license with a property, casualty and/or personal lines line of authority, who is regularly commissioned to represent two (2) or more fire and casualty insurance companies licensed to do business in the state.

(3) The privilege license shall continue from the date of issuance until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of twelve (12) months.

(4) A nonresident person shall receive a surplus lines insurance producer license if:

(a) The person is currently licensed as a surplus lines insurance producer or equivalent and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the biennial fee of One Hundred Dollars ($100.00); and

(c) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(5) A nonresident person shall not be required to hold an insurance producer license with a property, casualty and/or personal lines line of authority if the person is not required to perform a diligent search of admitted insurers as set forth in Section 83-21-23.

(6) The commissioner may verify a person's licensing status through the National Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(7) A nonresident surplus lines insurance producer licensee who moves from one (1) state to another state, or a resident surplus lines licensee who moves from this state to another state, shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(8) The commissioner may deny, suspend, revoke or refuse the license of a surplus lines insurance producer licensee and/or levy a civil penalty in an amount not to exceed Two Thousand Five Hundred Dollars ($2,500.00) per violation, after notice and hearing as provided hereunder, for one or more of the following grounds:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing the business of insurance;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive or dishonest practices or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(*l*) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation; or

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(9) If the action by the commissioner is to nonrenew, suspend, revoke or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner within ten (10) days for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty (30) days.

(10) Every surplus lines insurance contract procured and delivered according to Sections 83-21-17 through 83-21-31 shall have stamped upon it in bold ten-point type, and bear the name of the surplus lines insurance producer who procured it, the following: "NOTE: This insurance policy is issued pursuant to Mississippi law covering surplus lines insurance. The company issuing the policy is not licensed by the State of Mississippi, but is authorized to do business in Mississippi as a nonadmitted company. The policy is not protected by the Mississippi Insurance Guaranty Association in the event of the insurer's insolvency." No diminution of the license fee herein provided shall occur as to any license effective after January 1 of any year.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1977, ch. 397; Laws, 1988, ch. 526, § 9; Laws, 2000, ch. 606, § 1; Laws, 2009, ch. 448, § 13; Laws, 2011, ch. 380, § 3, eff from and after passage (approved Mar. 11, 2011).**

**Editor's Note** — Section 13 of ch. 526, Laws of 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

**Amendment Notes** — The 2009 amendment, effective November 1, 2009, substituted "biennial payment of a fee of One Hundred Dollars ($100.00)" for "annual payment of a fee of Fifty Dollars ($50.00)" in the first sentence; and added the second sentence.

The 2011 amendment rewrote the section.

**Cross References** — Licensing of agents generally, see § 83-17-5.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 89.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-21-21. Surplus lines policies.

(1) The Commissioner of Insurance may establish a stamping procedure for all eligible nonadmitted/surplus lines insurance policies sold on risks subject to the payment of premium taxes to the State of Mississippi.

(2) The Commissioner of Insurance may rely upon the advice and assistance of a duly constituted association of surplus lines insurance producers in carrying out the purposes of this chapter, if the association files with the commissioner:

(a) A copy of the association's constitution and articles of agreement of association or the association's certificate of incorporation and bylaws and any rules and regulations governing the association's activities;

(b) A list of the association's members; and

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued by the commissioner may be served.

(3) The Commissioner of Insurance may examine the association's records concerning the functions or duties performed on behalf of the commissioner by the association.

(4) The association shall provide a means for the examination of all surplus lines coverages written to determine whether such coverages comply with the law and such rules or regulations as may be issued by the Commissioner of Insurance.

(5) The Commissioner of Insurance may refuse to accept, or may suspend or revoke the acceptance of, an association for any of the following reasons:

(a) It reasonably appears that the association will not be able to carry out the purposes of this chapter;

(b) The association does not maintain and enforce rules and regulations which will ensure that members of the association and persons associated with those members will comply with this chapter, other applicable state law or rules or regulations promulgated under either;

(c) The rules or regulations of the association do not ensure a fair representation of its members in the selection of directors and in the administration of its affairs;

(d) The rules or regulations of the association do not provide for an equitable allocation of reasonable dues, fees and other charges among members;

(e) The rules or regulations of the association impose an undue burden on competition; or

(f) The association fails to meet other applicable requirements prescribed in this chapter.

(6) A surplus lines insurance producer shall cooperate with the association and the Commissioner of Insurance in fulfilling the surplus lines agent's statutory responsibility under this chapter.

(7) Upon request from the association, the Commissioner of Insurance may approve the levy of an examination fee of not more than one percent (1%) of premiums charged under this chapter for the operation of the association to the extent that such operation relieves the commissioner of duties otherwise required of the Commissioner of Insurance under this chapter.

(8) The association may revoke the membership of, and the Commissioner of Insurance may revoke the license in this state of, any licensee who fails to pay the examination fee when due, if the examination fee has been approved by the Commissioner of Insurance.

(9) The fees levied and collected by the association pursuant to this section shall be subject to transfer to the Department of Insurance Special Fund by act of the Legislature.

(10) The association, the association's board members and employees shall not be subject to liability for any functions or duties performed in good faith, from and after May 9, 2008, by the association pursuant to this chapter.

(11) In the alternative, the Commissioner of Insurance may contract with a third party to assist the commissioner with carrying out the purposes of this chapter. The third party may collect an examination fee in an amount determined by the commissioner but not more than one percent (1%) of premiums charged under this chapter. The fees shall be collected and deposited into the Department of Insurance Special Fund, and from this fund the department may pay the third party a reasonable fee for its services.

(12) Notwithstanding the provisions of Section 83-21-18(3), any stamping procedure established under this section may apply to the reporting, payment, collection and allocation of premium taxes for nonadmitted insurance consistent with any agreement, compact or procedures entered into by the commissioner under Section 83-21-18(1).

(13) The commissioner may promulgate rules and regulations necessary for the implementation of this section.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1997, ch. 467, § 1; Laws, 2002, ch. 321, § 1; Laws, 2004, ch. 555, § 15; Laws, 2008, ch. 539, § 1; Laws, 2009, ch. 440, § 1; Laws, 2011, ch. 380, § 4, eff from and after passage (approved Mar. 11, 2011.)**

**Editor's Note** — Laws of 2008, ch. 507, § 8, as amended by Laws of 2009, ch. 440, § 2, provides:

"SECTION 8. The State Fiscal Officer is directed to transfer the sum of Two Million Dollars ($2,000,000.00) from the Mississippi Surplus Lines Association to the Mississippi Department of Insurance Special Funds. Furthermore, should the association between the Mississippi Department of Insurance and the Mississippi Surplus Lines Association cease as to the collection of stamping fees, then any and all unexpended monies, interest and fees in excess of One Million Dollars ($1,000,000.00) collected and held by the Mississippi Surplus Lines Association shall immediately transfer to the State Fiscal Officer for the Mississippi Department of Insurance Special Funds."

**Amendment Notes** — The 2009 amendment extended the date of the repealer for subsection (10) by substituting "July 1, 2012" for "July 1, 2009" in the last sentence of (10).

The 2011 amendment inserted "insurance producers" in (2) and "insurance producer" in (6); deleted the last sentence in (10), which read: "This subsection (10) shall stand repealed from and after July 1, 2012"; added (12); and redesignated former (12) as present (13).

**Cross References** — Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

## JUDICIAL DECISIONS

1. Constitutionality.
2. Taking.

**1. Constitutionality.**

District court found that the Eleventh Amendment to the U.S. Constitution did not bar an association from proceeding with an action against Mississippi's fiscal officer in his official capacity, alleging that powers he was given under amendments to Miss. Code Ann. § 83-21-21 violated the Fifth and Fourteenth Amendments to the U.S. Constitution because he was able to take private property without just compensation, but that it could not hear claims the association made against the State of Mississippi or a claim it made against the fiscal officer which alleged that the amendments violated Miss. Const. Art. 3, § 17. Miss. Surplus Lines Ass'n v. Mississippi, 384 F. Supp. 2d 982 (S.D. Miss. 2005).

**2. Taking.**

Nonprofit corporation was accepted by the Insurance Commissioner as the association of surplus lines agents to provide the Commissioner with advice and assistance as provided in Miss. Code Ann. § 83-21-21(3); surplus funds collected by the nonprofit as examination fees under the auspices of the Commissioner were not private funds, so the taking of those funds did not offend the Constitution. Miss. Surplus Lines Ass'n v. Mississippi, 442 F. Supp. 2d 335 (S.D. Miss. 2006), affirmed by 261 Fed. Appx. 781, 2008 U.S. App. LEXIS 855 (5th Cir. Miss. 2008).

## ATTORNEY GENERAL OPINIONS

The Mississippi Surplus Lines Association (MSLA) is a nonprofit corporation which performs a governmental function, i.e., assisting the Commissioner of Insurance in the regulation of foreign insurance companies. As a nonprofit corporation, the MSLA would not be a "public body" as defined in §§ 25-41-3(a) or 25-61-3(a), and would not be subject to the requirements of the Open Meetings Law or the Mississippi Public Records Act of 1983. Dale, July 16, 2004, A.G. Op. 04-0300.

With regard to the State Tort Claims Act and sovereign immunity, the Mississippi Surplus Lines Association would not be within the definition of "political subdivision" therein and would not be subject to its provisions. Dale, July 16, 2004, A.G. Op. 04-0300.

With regard to the public purchasing and contracting provisions contained in §§ 31-7-1 et seq., the Mississippi Surplus Lines Association would not fall within the definition of "agency" or "governing authority" and, therefore, would not be subject to the provisions of that chapter. Dale, July 16, 2004, A.G. Op. 04-0300.

The officers and employees of the Mississippi Surplus Lines Association (MSLA) would not be public officers or public servants by virtue of their office or employment with MSLA and, consequently, the conflicts of interest provisions in Miss. Const., Art. 4, § 109 and § 25-4-101 et seq., prohibiting certain activities and business relationships by public officers and public servants and certain relatives, would not be applicable solely based on their relationships with the MSLA. However, these same individuals may be subject to these prohibitions if they hold public office or are employed by state or local government. Dale, July 16, 2004, A.G. Op. 04-0300.

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 89.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-21-23. Affidavit of surplus lines insurance producer; filing of affidavit and report; promulgation of rules and regulations and establishment of fees; exemption of certain surplus lines insurance producers from requirement to make due diligence search to determine availability of full amount or type of insurance from admitted insurers under certain circumstances.

(1) When any policy of insurance or certificate of insurance is procured under the authority of such license, there shall be executed by the surplus lines insurance producer an affidavit setting forth facts in complete detail as to what was done to place such kind of insurance and showing that such surplus lines insurance producer therein was unable, after diligent effort, to procure from any licensed company or companies the full amount of insurance required to protect the property, liability, or risk desired to be insured, and further showing that the amount of insurance procured from the eligible nonadmitted insurer or insurers is only the excess over the amount so procurable from licensed companies. Each such affidavit, which shall be effective for the term of the policy, shall be filed with the Commissioner of Insurance along with the report required in Section 83-21-25.

The Commissioner of Insurance may promulgate rules and regulations and establish appropriate fees for the implementation of Sections 83-21-17 through 83-21-31.

(2)(a) A surplus lines insurance producer is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the surplus lines insurance producer is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser provided:

(i) The surplus lines insurance producer procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(ii) The exempt commercial purchaser has subsequently requested in writing for the surplus lines insurance producer to procure or place such insurance from a nonadmitted insurer.

(b) The term "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager, as defined in Section 527(13) of the Nonadmitted and Reinsurance Reform Act of 2010, to negotiate insurance coverage.

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of One Hundred Thousand Dollars ($100,000.00) in the immediately preceding twelve (12) months.

(iii)1. The person meets at least one (1) of the following criteria:

a. The person possesses a net worth in excess of Twenty Million Dollars ($20,000,000.00) as such amount is adjusted according to item 2 of this subparagraph (iii).

b. The person generates annual revenues in excess of Fifty Million Dollars ($50,000,000.00) as such amount is adjusted according to item 2 of this subparagraph (iii).

c. The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate.

d. The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least Thirty Million Dollars ($30,000,000.00) as such amount is adjusted according to item 2 of this subparagraph (iii).

e. The person is a municipality with a population in excess of fifty thousand (50,000) persons.

2. Effective on January 1, 2015, and every five (5) years thereafter, the amounts in items 1a, 1b and 1d of this subparagraph (iii) shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Federal Bureau of Labor Statistics of the United States Department of Labor.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; § 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 1; Laws, 1995, ch. 314, § 1; Laws, 2000, ch. 606, § 2; Laws, 2011, ch. 380, § 5, eff from and after passage (approved Mar. 11, 2011.)**

**Amendment Notes —** The 2011 amendment substituted "surplus lines insurance producer" for "agent" twice in present (1); deleted former last sentence of second paragraph which read: "The Commissioner of Insurance shall also have authority to impose penalties for an agent's noncompliance with Sections 83-21-17 through 83-21-31 or rules and regulations hereunder including civil penalties not to exceed Two Thousand Five Hundred Dollars ($2,500.00) per violation or revocation of the agent's license, or both"; and added (2).

**Cross References** — Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

**Federal Aspects** — Nonadmiteed and Reinsurance Reform Act of 2010, see 15 USCS § 8201 et seq.

### ATTORNEY GENERAL OPINIONS

Potential insured who wishes to purchase insurance in Mississippi must purchase coverage for those risks, including amount of coverage of risk, which can be covered by admitted company before seeking to cover risks, or higher limits on risks, from approved but nonadmitted companies. Jackson, July 15, 1992, A.G. Op. #92-0450.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 89.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-21-25. Report of surplus lines insurance producer; "gross premiums"; designation of procuring surplus lines insurance producer to make report and payment.

The surplus lines insurance producer shall report under oath to the Commissioner of Insurance, within thirty (30) days from the first of January and July of each year, the amount of gross premiums received by him for such insurance in nonadmitted insurers, and shall pay to the Commissioner of Insurance a tax of four percent (4%) thereon. The term "gross premiums" shall mean the total gross amount of premiums received on each and every surplus lines insurance contract, less returned premiums. In default of the payment of any sum which may be due the state under this law, the Commissioner of Insurance may sue for the same. The surplus lines insurance producer shall keep a separate record of all transactions, as herein provided, open at all times to the inspection of the Commissioner of Insurance. The surplus lines insurance producer may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted insurer to report and pay, on behalf of the surplus lines insurance producer, to the Commissioner of Insurance the tax due the state under this law. The surplus lines insurance producer designated to pay the tax shall be deemed to have the same obligations and responsibilities for reporting and paying the tax due the state on the insurance procured from the nonadmitted insurer as the surplus lines insurance producer who was initially responsible for reporting and paying the tax, and the Commissioner of Insurance may sue such surplus lines insurance producer designated to pay the tax in the event such surplus lines insurance producer is in default of any sum which is due the state for which the designated surplus lines insurance producer is responsible or obligated to pay.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 2; Laws, 2011, ch. 380, § 6, eff from and after passage (approved Mar. 11, 2011.)**

**Amendment Notes** — The 2011 amendment rewrote the section to substitute "surplus lines insurance producer" for references to "agent" and "agent so licensed" and "nonadmitted insurer" for "nonlicensed insurer" throughout.

**Cross References** — Privilege taxes on agents, see §§ 27-15-87 et seq.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 89.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-21-27. Permissible acts of surplus lines insurance producers.

Nothing contained in Sections 83-21-17 through 83-21-31 shall authorize any person, firm, association, or corporation to guarantee or otherwise validate or secure the performance or legality of any agreement, instrument, or policy of insurance of any nonadmitted insurer, nor to permit or authorize any nonadmitted insurer to do any insurance business by or through any person or surplus lines insurance producer acting within this state; but surplus lines insurance producers licensed hereunder acting pursuant to the cited sections may issue and deliver to their clients, the insured, binders, policies, and other confirmation of direct insurance so lawfully placed, and shall not be personally liable to the holder of any policy of insurance so issued or delivered for any loss covered thereby.

**SOURCES: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-03; Laws, 1954, ch. 307, § 3; Laws, 1958, ch. 448, § 2; Laws, 2011, ch. 380, § 7, eff from and after passage (approved Mar. 11, 2011).**

**Amendment Notes** — The 2011 amendment substituted "surplus lines insurance producer" for "agent" throughout; and substituted "nonadmitted insurer" for "insurer not licensed" and "nonlicensed insurer" throughout.

**Cross References** — Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

### JUDICIAL DECISIONS

**1. In general.**

Assumption agreement by which non-admitted insurer assumed liability under policy written by another non-admitted insurer was an effort on the part of the second insurer to validate the original policy and guarantee the performance thereof, and was contrary to the provisions of this statute. Goff v. Dixon, 311 So. 2d 642 (Miss. 1975).

Where agent who was not licensed to place insurance with non-admitted companies and agent who was so licensed shared commissions paid for insurance which was not lawfully placed with non-admitted company, agents were joint adventurers and jointly and severally liable under this statute. Goff v. Dixon, 311 So. 2d 642 (Miss. 1975).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 89.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-21-29. Suits against nonadmitted insurers.

A nonadmitted insurer may be sued upon any cause of action arising in this state under any contract issued by it as hereinabove authorized, in a court of competent jurisdiction in any county in which the plaintiff may reside, or in which the cause of action arose. Any such policy or contract shall contain a provision authorizing service of citation or other legal process upon a person or firm whose name and address shall be set out therein, which said person, or at least one (1) member of a firm, shall be a resident of Mississippi. In lieu thereof any such policy or contract shall contain a provision authorizing service of citation or other legal process upon the Commissioner of Insurance, designating the person to whom said Commissioner of Insurance shall mail citation or other legal process. In the event service of legal process against a nonadmitted insurer is made by service upon the Commissioner of Insurance, he shall forthwith mail citation or other document or process required to the person designated by the nonadmitted insurer in the policy for the purpose by registered mail or certified mail with return receipt requested. In the event of service of citation or other legal process upon the Commissioner of Insurance, the nonadmitted insurer shall have thirty (30) days from date of service upon said Commissioner of Insurance within which to plead, answer, or otherwise defend the action. Upon service of process upon the Insurance Commissioner in accordance with this law, or upon the person or firm designated in the policy or contract in accordance with this law, or as provided for by the Mississippi Rules of Civil Procedure, the court shall be deemed to have jurisdiction in personam of the nonadmitted insurer. A nonadmitted insurer issuing such insurance policy or contract shall be deemed thereby to have authorized service of process upon it in the manner and effect as provided in Sections 83-21-17 through 83-21-31, and as provided in the Mississippi Rules of Civil Procedure.

**SOURCES: Codes, 1942, § 5705-04; Laws, 1954, ch. 307, § 4; Laws, 1958, ch. 448, § 3; Laws, 1991, ch. 573, § 121; Laws, 2011, ch. 380, § 8, eff from and after passage (approved Mar. 11, 2011).**

**Amendment Notes —** The 2011 amendment substituted “nonadmitted insurer” for ”nonlicensed insurer” throughout; and made a minor stylistic change.

**Cross References —** Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

For the rule governing service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-31. Application of preceding and succeeding sections.

As to any policy or contract issued pursuant to Sections 83-21-17 through 83-21-31, and as to any claim for loss or damage arising under any such policy or contract, the cited sections shall apply. As to any such policy or contract issued by an unauthorized insurer in a manner not provided in said preceding sections, Sections 83-21-33 through 83-21-51 shall apply.

**SOURCES: Codes, 1942, § 5705-05; Laws, 1954, ch. 307, § 5.**

**Cross References —** Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

### JUDICIAL DECISIONS

**1. In general.**

In determining the status as an agent of an individual arranging insurance with an unauthorized insurer, § 83-17-1 was the appropriate section for determining agency where the sections listed in § 83-21-31 as particularly applicable to policies issued by unauthorized insurers did not refer to acts sufficient to constitute an agency relationship. Southeastern Fid. Ins. Co. v. Gann, 340 So. 2d 429 (Miss. 1976).

## UNAUTHORIZED INSURERS PROCESS LAW

SEC.

83-21-33. Citation.
83-21-35. Service of process upon unauthorized insurers.
83-21-37. Acts constituting commissioner as agent.
83-21-39. Method of service.
83-21-41. Personal service on agent or representative.
83-21-43. Time allowed before judgment.
83-21-45. Defense of action by unauthorized insurer.
83-21-47. Discretionary continuances.
83-21-49. Motions to quash or set aside service.
83-21-51. Attorney fees.

## § 83-21-33. Citation.

Sections 83-21-33 through 83-21-51 may be cited as "The Unauthorized Insurers Process Law."

**SOURCES: Codes, 1942, § 5705-21; Laws, 1958, ch. 450, § 11.**

### RESEARCH REFERENCES

**Practice References.** Thomas, Jeffrey E., Martinez, Leo P., Mayerson, Marc S., and Richmond, Douglas R., 2011 Edition of New Appleman Insurance Law Practice Guide.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

## § 83-21-35. Service of process upon unauthorized insurers.

The purpose of Sections 83-21-33 through 83-21-51 is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts. The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered them in this state by insurers not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interests, the legislature herein provides a method of substituted service of process upon such insurers, declares that in so doing it exercises its power to protect its residents and to define, for the purpose of the cited sections, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, first session, Section 340, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

**SOURCES: Codes, 1942, § 5705-11; Laws, 1958, ch. 450, § 1.**

**Cross References —** The rule governing service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

**Federal Aspects —** Public Law 15, 79th Congress, Chapter 20, § 340, 15 USCS § 1011 et seq.

### JUDICIAL DECISIONS

**1. In general.**

Code 1942, §§ 5705-11 and 5705-12 are in pari materia and must be construed with reference to each other, and in so doing it appears that the legislative intent was that § 5705-12 (the long-arm statute) would be effective when policies of insurance were issued or delivered to policyholders within the state, and it was not intended, without more, that the section would be effective to constitute the insurance commissioner as the agent of an insurance corporation merely authorized to do business, but not actually doing business, within the state. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307 (Miss. 1968).

Where a foreign insurance company issued and delivered in California a policy of group insurance to plaintiff's employer, a corporation authorized to do business in Mississippi, plaintiff's premiums thereon were not paid to the insurer directly by plaintiff but were deducted and paid by the employer, and the insurer had never applied to do business in Mississippi, had no agents or other individuals in any capacity within the state, and did not solicit business by mail there, the fact that the insurer paid part of plaintiff's hospital bill there was an insufficient minimal contract with Mississippi to constitute the insurance commissioner its agent for service of process in plaintiff's Mississippi action on the contract. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307 (Miss. 1968).

### ATTORNEY GENERAL OPINIONS

An agent for an unlicensed insurer would be subject to the tax specified in Section 83-21-25. Ford, Sept. 16, 2005, A.G. Op. 05-0395.

### RESEARCH REFERENCES

**ALR.** Foreign insurance company as subject to service of process in action on policy. 44 A.L.R.2d 416.

**Am Jur.** 43 Am. Jur. 2d,Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

## § 83-21-37. Acts constituting commissioner as agent.

Any of the following acts in this state, effected by mail or otherwise, by an unauthorized or alien insurer: (1) the issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments, or other considerations for such contracts, or (4) any other transaction of insurance business is equivalent to and shall constitute an appointment by such insurer of the commissioner of insurance and his successor or successors in office to be its true and lawful agent, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance, and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

**SOURCES: Codes, 1942, § 5705-12; Laws, 1958, ch. 450, § 2.**

**Cross References —** For the rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

### JUDICIAL DECISIONS

**1. In general.**

Code 1942, §§ 5705-11 and 5705-12 are in pari materia and must be construed with reference to each other, and in so doing it appears that the legislative intent was that § 5705-12 (the long-arm statute) would be effective when policies of insurance were issued or delivered to policyholders within the state, and it was not intended, without more, that the section would be effective to constitute the insurance commissioner as the agent of an insurance corporation merely authorized to do business, but not actually doing business, within the state. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307 (Miss. 1968).

Where a foreign insurance company issued and delivered in California a policy of group insurance to plaintiff's employer, a corporation authorized to do business in Mississippi, plaintiff's premiums thereon were not paid to the insurer directly by plaintiff but were deducted and paid by the employer, and the insurer had never applied to do business in Mississippi, had no agents or other individuals in any capacity within the state, and did not solicit business by mail there, the fact that the insurer paid part of plaintiff's hospital bill there was an insufficient minimal contact with Mississippi to constitute the insurance commissioner its agent for service of process in plaintiff's Mississippi action on the contract. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307 (Miss. 1968).

### RESEARCH REFERENCES

**ALR.** Foreign insurance company as subject to service of process in action on policy. 44 A.L.R.2d 416.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

## § 83-21-39. Method of service.

Such service of process shall be made by delivering to and leaving with the commissioner of insurance, or some person in apparent charge of his office, two (2) copies thereof and the payment to him of such fees as may be prescribed by law. The commissioner of insurance shall forthwith mail by registered mail or certified mail one of the copies of such process to the defendant at its last known principal place of business, and shall keep a record of all process so served upon him. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within ten (10) days thereafter by registered mail or certified mail by plaintiff or plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

**SOURCES: Codes, 1942, § 5705-13; Laws, 1958, ch. 450, § 3.**

**Cross References** — Requirement that advisory organization assisting insurer submit at time of registration service and acknowledgement of service of process, see § 83-2-17.

For the rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-41. Personal service on agent or representative.

Service of process in any such action, suit or proceeding shall, in addition to the manner provided in Section 83-21-39, be valid if served upon any person within the state who, in this state on behalf of such insurer, is (1) soliciting insurance, or (2) making, issuing or delivering any contract or insurance, or (3) collecting or receiving any premium, membership fee, assessment, or other consideration for insurance; and a copy of such process is sent within ten (10) days thereafter by registered mail or certified mail by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow. Nothing in Sections 83-21-33 through 83-21-51 shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or hereafter permitted by law or the Mississippi Rules of Civil Procedure.

**SOURCES: Codes, 1942, § 5705-14; Laws, 1958, ch. 450, § 4; Laws, 1991, ch. 573, § 122, eff from and after July 1, 1991.**

**Cross References** — The rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

## § 83-21-43. Time allowed before judgment.

No plaintiff or complainant shall be entitled to a judgment by default, or a judgment with leave to prove damages, or a judgment pro confesso under Sections 83-21-33 through 83-21-51, until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

**SOURCES: Codes, 1942, § 5705-15; Laws, 1958, ch. 450, § 5.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-45. Defense of action by unauthorized insurer.

Before any unauthorized insurer shall file or cause to be filed any pleading in any action, suit, or proceeding instituted against it, such unauthorized insurer shall either (1) deposit cash or securities with the clerk of the court in which such action, suit, or proceeding is pending, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such actions; or (2) procure a certificate of authority to transact the business of insurance in this state.

**SOURCES: Codes, 1942, § 5705-16; Laws, 1958, ch. 450, § 6.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-47. Discretionary continuances.

The court, in any action, suit, or proceeding in which service is made in the manner provided in Sections 83-21-33 through 83-21-51, may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Section 83-21-45 and to defend such action.

**SOURCES: Codes, 1942, § 5705-17; Laws, 1958, ch. 450, § 7.**

### RESEARCH REFERENCES

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-49. Motions to quash or set aside service.

Nothing in Sections 83-21-33 through 83-21-51 is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ, or to set aside service thereof made in the manner provided herein, on the ground either (1) that such unauthorized insurer has not done any of the acts enumerated in Section 83-21-37, or (2) that the person on whom service was made pursuant to Section 83-21-41 was not doing any of the acts therein enumerated.

**SOURCES: Codes, 1942, § 5705-18; Laws, 1958, ch. 450, § 8.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 94.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

## § 83-21-51. Attorney fees.

In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twenty-five percent (25%) of the amount which the court or jury finds that the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than Twenty-five Dollars ($25.00). Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

**SOURCES: Codes, 1942, § 5705-19; Laws, 1958, ch. 450, § 9.**

### JUDICIAL DECISIONS

**1. In general.**

In an insurance policy action in which the insured did not establish that his insurer's refusal to make payment was vexatious and without reasonable cause, he was not allowed the reasonable attorney's fee authorized by statute. America Southwest Corp. v. Underwriters at Lloyds, London, 333 F. Supp. 1333 (S.D. Miss. 1971).

An insurance company which refused to make payment on the ground that there was no coverage under the terms of the policy was not liable for attorney's fees under this section [Code 1942, § 5705-19], where the evidence failed to establish that its refusal was made vexatiously and without reasonable cause. America Southwest Corp. v. Underwriters at Lloyds, London, 333 F. Supp. 1333 (S.D. Miss. 1971).

### RESEARCH REFERENCES

**Am Jur.** 44A Am. Jur. 2d, Insurance § 1521.

**CJS.** 44 C.J.S., Insurance § 137.

**Lawyers' Edition.** State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

# CHAPTER 23

## Insolvent Insurance Companies; Insurance Guaranty Association

Article 1. Insolvent Companies .......... 83-23-1
Article 3. Insurance Guaranty Association .......... 83-23-101
Article 5. Mississippi Life and Health Insurance Guaranty Association Act .......... 83-23-201

### ARTICLE 1.

### INSOLVENT COMPANIES.

SEC.
83-23-1. Receivers.
83-23-3. Certain receiverships dispensed with.
83-23-5. Commissioner designated as receiver.
83-23-7. Powers of the court in receiverships.
83-23-9. Application of article.

## § 83-23-1. Receivers.

Whenever it shall appear to the commissioner of insurance of this state that any insurance company incorporated in this state, or incorporated out of this state but doing business herein, (1) is insolvent, or (2) is in such condition that its further transaction of business will be hazardous to its policyholders, to its creditors, or to the public, or (3) has been placed in receivership or liquidation or rehabilitation in some other state or jurisdiction, it shall be his duty to file a petition in the chancery court of the proper county, setting up the facts and praying the appointment of a receiver for such company. If any of said grounds shall exist and the commissioner shall neglect to file such petition, then it may be filed by the attorney general. All laws of this state with respect to receivers shall apply in such proceeding, except that no application for the appointment of a receiver of any insurance company shall be entertained by any court unless filed by one of said officials.

**SOURCES: Codes, 1942, § 5643; Laws, 1938, ch. 195; Laws, 1958, ch. 434, § 1.**

**Cross References** — Duty of attorney general to represent state officer in suit brought in official capacity, see § 7-5-39.

Jurisdiction of chancery court to appoint receiver, see § 11-5-151.

Suspension or revocation of certificates of authority on ground of unsound condition, see § 83-1-29.

When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

Powers of Mississippi Life and Health Insurance Guaranty Association with respect to insolvent insurers, see § 83-23-215.

Commissioner's duty to notify Mississippi Life and Health Insurance Guaranty Association with respect to insolvency or impairment of member insurers, see § 83-23-221.

Stay of all actions involving insolvent insurance companies to permit Mississippi Life and Health Insurance Guaranty Association to intervene, see § 83-23-233.

### JUDICIAL DECISIONS

**1. In general.**

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424 (1944).

### RESEARCH REFERENCES

**Practice References.** Thomas, Jeffrey E., Martinez, Leo P., Mayerson, Marc S., and Richmond, Douglas R., 2011 Edition of New Appleman Insurance Law Practice Guide.

**ALR.** What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 43 (complaint or declaration, in nature of quo warranto, for order appointing receiver for insurance company and enjoining transaction of business).

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-3. Certain receiverships dispensed with.

In the event the company in receivership is a foreign company and a receiver has been appointed in the state of domicile of the impaired company, the court shall dispense with the Mississippi receivership unless the court is of the opinion that a Mississippi receivership will best serve the interest of Mississippi policyholders and claimants.

**SOURCES: Codes, 1942, § 5643; Laws, 1938, ch. 195; Laws, 1958, ch. 434, § 2.**

**Cross References —** When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

### JUDICIAL DECISIONS

**1. In general.**

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424 (1944).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 151.

**CJS.** 44 C.J.S., Insurance § 185.

## § 83-23-5. Commissioner designated as receiver.

In event of the appointment of a receiver of any insurance company, the chancery court having jurisdiction shall designate the commissioner of insurance as such receiver. He shall serve as such without compensation other than his regular salary, but the chancery court may authorize the payment of his actual expenses incurred, and may authorize the employment and compensation of such employees, assistants, and attorneys as may be required in the administration of such receivership.

**SOURCES: Codes, 1942, § 5644; Laws, 1938, ch. 195.**

**Cross References —** When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

## § 83-23-7. Powers of the court in receiverships.

In the administration of any receivership of an insurance company hereunder, the chancery court having jurisdiction may make all necessary orders, including, among others, (1) an order or orders to rehabilitate such company, which may direct the receiver to take possession of the property of such company, conduct the business thereof, and take such steps toward the removal of the causes and conditions which have made a receivership necessary as the court may direct, (2) an order or orders to liquidate such company, (3) an order or orders to terminate such receivership and permit such insurance company to resume possession of its property and the conduct of its business, and (4) an order or orders to conserve the assets of such insurance company within this state.

**SOURCES: Codes, 1942, § 5645; Laws, 1938, ch. 195.**

**Cross References —** When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

### RESEARCH REFERENCES

**ALR.** Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 150 et seq.

**CJS.** 44 C.J.S., Insurance §§ 195 et seq.

## § 83-23-9. Application of article.

This article shall apply to original receiverships and to ancillary receiverships.

This article shall apply to all insurance companies operating under the insurance laws of this state including stock, mutual, fraternal benefit, and reciprocal or interinsurance companies, and to all corporations operating under Sections 83-41-201 through 83-41-217.

**SOURCES: Codes, 1942, § 5646; Laws, 1938, ch. 195; Laws, 1997, ch. 307, § 4, eff from and after July 1, 1997.**

### ARTICLE 3.

### INSURANCE GUARANTY ASSOCIATION.

SEC.
83-23-101. Title.
83-23-103. Purpose.
83-23-105. Application of article; exceptions.
83-23-107. Construction.
83-23-109. Definitions.
83-23-111. Creation of the association.
83-23-113. Board of directors.
83-23-115. Powers and duties of association.
83-23-117. Plan of operation.
83-23-119. Duties and powers of the commissioner.
83-23-121. Assignment of rights to association; effect of paid claims.
83-23-123. Nonduplication of recovery.
83-23-125. Prevention of insolvencies.
83-23-127. Examination of the association.
83-23-129. Tax exemption.
83-23-131. Recognition of assessments in rates.
83-23-133. Immunity.
83-23-135. Stay of proceedings; access to insolvent insurer's records.
83-23-137. Proposal for disbursal of assets of insolvent insurer; application for approval.

## § 83-23-101. Title.

This article shall be known and may be cited as the Mississippi Insurance Guaranty Association Law.

**SOURCES: Codes, 1942, § 5814-51; Laws, 1970, ch. 446, § 1, eff from and after passage (approved April 6, 1970).**

**Cross References** — Mississippi Life and Health Insurance Guaranty Association Act, see §§ 83-23-201 et seq.

Applicability of this chapter to nonprofit medical liability insurance corporations, see § 83-47-23.

### JUDICIAL DECISIONS

1. In general.
2. Illustrative cases.

**1. In general.**

As a matter of law, the Mississippi Insurance Guaranty Association cannot be liable for punitive damages. Bobby Kitchens, Inc. v. Mississippi Ins. Guar. Ass'n, 560 So. 2d 129 (Miss. 1989).

**2. Illustrative cases.**

In suit by an auto accident victim against the tortfeasor's employer's insurer, which became insolvent, the trial court properly granted the Mississippi Insurance Guaranty Association summary judgment, as the policy at issue excluded coverage for injuries arising from auto accidents, and the fact that the victim pled theories of negligent hiring and failure to maintain adequate safety programs did not defeat the exclusion. Meyers v. Miss. Ins. Guar. Ass'n, 883 So. 2d 10 (Miss. 2003).

### RESEARCH REFERENCES

**Practice References.** Thomas, Jeffrey E., Martinez, Leo P., Mayerson, Marc S., and Richmond, Douglas R., 2011 Edition of New Appleman Insurance Law Practice Guide.

**ALR.** Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

## § 83-23-103. Purpose.

The purpose of this article is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

**SOURCES: Codes, 1942, § 5814-52; Laws, 1970, ch. 446, § 2, eff from and after passage (approved April 6, 1970).**

**Cross References —** Applicability of this article to nonprofit medical liability insurance corporations, see § 83-47-23.

### JUDICIAL DECISIONS

**1. In general.**

Summary judgment was properly granted in favor of the guaranty association where the insurer's failure to settle within the policy limits when the offer was made, combined with its failure to inform its insured of such offer, automatically operated to extend the insurer's limits to the full amount of the judgment rendered; the insurer did not have standing to bring the suit since its policy limits were extended to cover the entire judgment against the corporation, and no subrogation would be allowed under Miss. Code Ann. § 83-23-103. Home Ins. Co. v. Miss. Ins. Guar. Ass'n, 904 So. 2d 95 (Miss. 2004).

The sole purpose of the Mississippi Insurance Guaranty Association (MIGA) is to protect the insured from insolvent insurance companies and to require the financially healthy insurance companies to involuntarily contribute to protect the public. Because of MIGA's involuntary nature, the legislature rightfully placed limitations on the liabilities of Association members. Even so restricted, however, the purpose of protecting the public or claimants against financial loss because of insolvency of insurers must be achieved. To achieve this desirable result, the statute creating MIGA must be liberally construed. Bobby Kitchens, Inc. v. Mississippi Ins. Guar. Ass'n, 560 So. 2d 129 (Miss. 1989).

### RESEARCH REFERENCES

**ALR.** Validity, construction and effect of Uniform Insurer's Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance, §§ 93, 94 et seq., 148.

**CJS.** 44 C.J.S., Insurance § 182.

## § 83-23-105. Application of article; exceptions.

This article shall apply to all kinds of direct insurance except the following:

(a) Life, annuity, health or disability insurance;

(b) Mortgage guaranty, financial guaranty or other forms of insurance offering protection against insolvent risks;

(c) Fidelity or surety bonds, or any other bonding obligations;

(d) Credit insurance;

(e) Insurance of warranties or service contracts;

(f) Title insurance;

(g) Ocean marine insurance;

(h) Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; and

(i) Any insurance provided by or guaranteed by government.

**SOURCES: Codes, 1942, § 5814-53; Laws, 1970, ch. 446, § 3; Laws, 1992, ch. 412, § 1, eff from and after July 1, 1992.**

**Cross References —** Definition of "member insurer", see § 83-23-109.

Insurance guaranty association for life and health insurance, see §§ 83-23-201 et seq.

### JUDICIAL DECISIONS

**1. In general.**

Chancellor did not err in finding in favor of the insurance companies in their action, in part, for reimbursement of claims because claims at issue were covered claims under direct insurance; therefore, the Mississippi Insurance Guaranty Association was responsible for paying those claims under Miss. Code Ann. § 83-23-105, and was required to reimburse the insurance companies. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865 (Miss. 2006).

Major medical insurance or accident and health insurance is exempt from Mississippi Insurance Guaranty Association insolvency coverage. Mississippi Ins. Guar. Ass'n v. Vaughn, 529 So. 2d 540 (Miss. 1988).

Liability of insurance guaranty association is not limited to claims arising after the effective date of the act creating the association, but extends to any claim antedating insolvency. Mississippi Ins. Guar. Ass'n v. Gandy, 289 So. 2d 677 (Miss. 1973).

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-107. Construction.

This article shall be liberally construed to effect the purpose under Section 83-23-103, which shall constitute an aid and guide to interpretation.

**SOURCES: Codes, 1942, § 5814-54; Laws, 1970, ch. 446, § 4, eff from and after passage (approved April 6, 1970).**

JUDICIAL DECISIONS

**1. In general.**

The Mississippi Insurance Guaranty Association Law (§ 83-23-101 et seq) is to be liberally construed in order to achieve the purpose of protecting the public or claimants against financial loss because of the insolvency of insurers. Mississippi Ins. Guar. Ass'n v. Byars, 614 So. 2d 959 (Miss. 1993).

The sole purpose of the Mississippi Insurance Guaranty Association (MIGA) is to protect the insured from insolvent insurance companies and to require the financially healthy insurance companies to involuntarily contribute to protect the public. Because of MIGA's involuntary nature, the legislature rightfully placed limitations on the liabilities of Association members. Even so restricted, however, the purpose of protecting the public or claimants against financial loss because of insolvency of insurers must be achieved. To achieve this desirable result, the statute creating MIGA must be liberally construed. Bobby Kitchens, Inc. v. Mississippi Ins. Guar. Ass'n, 560 So. 2d 129 (Miss. 1989).

## § 83-23-109. Definitions.

As used in this article:

(a) "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(b) "Association" means the Mississippi Insurance Guaranty Association created under Section 83-23-111.

(c) "Claimant" means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Control" means the possession, direct or indirect, of the power to direct or cause direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(f) "Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this article applies issued by an insurer, if such insurer becomes an insolvent insurer and (1) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or (2) the property from which the claim arises is permanently located in this state. "Covered claim" shall not include any amount awarded as punitive or exemplary damages; or sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise and shall preclude recovery thereof from the insured of any insolvent carrier to the extent of the policy limits.

(g) "Insolvent insurer" means an insurer licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred and against whom an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, in the insurer's state of domicile or of this state and the order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(h) "Member insurer" means any person who (1) writes any kind of insurance to which this article applies under Section 83-23-105, including the exchange of reciprocal or interinsurance contracts, and (2) is licensed to transact insurance in this state.

(i) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this article applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(j) "Person" means any individual, corporation, partnership, association, or voluntary organization.

**SOURCES: Codes, 1942, § 5814-55; Laws, 1970, ch. 446, § 5; Laws, 1992, ch. 412, § 2, eff from and after July 1, 1992.**

## JUDICIAL DECISIONS

1. In general.
2. Covered claims.

**1. In general.**

Trial court correctly granted Mississippi Insurance Guaranty Association's motion for summary judgment on the corporation's action for declaratory relief and damages where, pursuant to Miss. Code Ann. § 83-23-109(f), the underlying tort claimants were not claimants, the corporation was the one asserting the claim; however, residency was not met by the corporation and the claim was not a covered claim. Owens Corning v. Miss. Ins. Guar. Ass'n, 947 So. 2d 944 (Miss. 2007).

Guaranty association was not liable for insurance policy issued to a property company by an insolvent insurer, as the insurer was not a member of the association, and no assessments were ever collected by the guaranty association. Miss. Ins. Guar. Ass'n v. Goldin Props., 893 So. 2d 1062 (Miss. Ct. App. 2004), cert. denied, 893 So. 2d 1061 (Miss. 2005).

An insurance claim arose from a well, which was permanently located in Mississippi, rather than the well's tubing, which was easily transported, and was therefore covered under § 83-23-109, even though some of the damages claimed necessarily involved the tubing indirectly, where all of the claimed damages were in some way concerned either with the well itself or with steps taken to return the well to useful service. Mississippi Ins. Guar. Ass'n v. Harkins & Co., 652 So. 2d 732 (Miss. 1995).

An unpaid insurance claim qualified as a "covered claim" under § 83-23-109(c), even though the insurance policy was purchased as a surplus lines policy in Louisiana, where the insurance company was licensed in Mississippi at the applicable time. Mississippi Ins. Guar. Ass'n v. Harkins & Co., 652 So. 2d 732 (Miss. 1995).

An insurance claim was a "covered claim" under the Mississippi Insurance Guaranty Association Law (§§ 83-23-101 et seq.), even though the insured was a Michigan corporation and not a Mississippi resident, where the claimant was a resident of Mississippi, since § 83-23-109(c) requires that the insured or the claimant be a resident of Mississippi in order to fall under the Mississippi Insurance Guaranty Association's umbrella. Mississippi Ins. Guar. Ass'n v. Byars, 614 So. 2d 959 (Miss. 1993).

**2. Covered claims.**

Insured's claim against his uninsured motorist carrier was a covered claim under Miss. Code Ann. § 83-23-109(f) because at the time of the insured's accident with a truck, the truck was insured by an insurance company that had since been declared an insolvent insurer within the meaning of § 83-23-109; therefore, the insured's claim was unquestionably a "covered claim," a claim against the Mississippi Insurance Guaranty Association. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396 (Miss. 2010).

Summary judgment was properly granted to the Mississippi Insurance Guaranty Association because it was entitled to offset an amount recovered by an injured party from its own insurer under Miss. Code Ann. § 83-23-123 since a covered claim was filed under Miss. Code Ann. § 83-23-109(f) under an uninsured motorist provision. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405 (Miss. Ct. App. 2009), affirmed by 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Under Miss. Code Ann. § 83-23-109(f), a covered claim is an unpaid claim, with a few restrictions, that is issued by an insurer, if such insurer becomes an insolvent insurer and meets condition (1) or (2) of the definition. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407 (Miss. 2007).

Clear and unambiguous key to the definition of covered claim is that a covered claim, under the Mississippi Insurance Guaranty Association Law, relates to circumstances involving a once-solvent insurer that becomes insolvent. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407 (Miss. 2007).

Mother and child were not required to first exhaust their rights under an insurance policy as set forth in Miss. Code Ann. § 83-23-123(1) where their physicians' insurance carrier had remained solvent at all times, and as a result the claim against them related to the birth of the child was not a covered claim. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407 (Miss. 2007).

Chancellor did not err in finding in favor of the insurance companies in their action, in part, for reimbursement of claims because claims at issue were "covered claims" under direct insurance; therefore, the Mississippi Insurance Guaranty Association was responsible for paying those claims under Miss. Code Ann. § 83-23-109(f), and was required to reimburse the insurance companies. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865 (Miss. 2006).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-111. Creation of the association.

There is created a nonprofit unincorporated legal entity to be known as the Mississippi Insurance Guaranty Association. All insurers defined as member insurers in Section 83-23-109 shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under Section 83-23-117 and shall exercise its powers through a board of directors established under Section 83-23-113.

**SOURCES: Codes, 1942, § 5814-56; Laws, 1970, ch. 446, § 6, eff from and after passage (approved April 6, 1970).**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 63.

## § 83-23-113. Board of directors.

(1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons, serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the commissioner. Vacancies of the board shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the commissioner. If no members are selected within sixty (60) days after July 1, 1992, the commissioner may appoint the initial members of the board of directors.

(2) In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

**SOURCES: Codes, 1942, § 5814-57; Laws, 1970, ch. 446, § 7; Laws, 1992, ch. 412, § 3, eff from and after July 1, 1992.**

**Cross References** — Plan of operation, see § 83-23-117.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 67.

## § 83-23-115. Powers and duties of association.

(1) The association shall:

(a) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation if he does so within thirty (30) days of the determination. Such obligation shall be satisfied by paying the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) An amount in excess of Fifty Dollars ($50.00) per policy for a covered claim for the return of unearned premium;

(iii) An amount in excess of Fifty Dollars ($50.00) but not exceeding Three Hundred Thousand Dollars ($300,000.00) per claimant for all other covered claims.

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(b) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

(c) Assess insurers amounts necessary to pay the obligations of the association under paragraph (a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under Section 83-23-125 and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year an amount greater than one percent (1%) of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off, against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.

(d) Investigate claims brought against the association; adjust, compromise, settle, and pay covered claims to the extent of the association's obligation; deny all other claims; and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties, to determine the extent to which such settlements, releases, and judgments may be properly contested.

(e) Notify such persons as the commissioner directs under Section 83-23-119(2)(a).

(f) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association, and shall pay the other expenses of the association authorized by this article.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this article in accord with the plan of operation.

(c) Sue or be sued.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this article.

(e) Perform such other acts as are necessary or proper to effectuate the purpose of this article.

(f) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

**SOURCES: Codes, 1942, § 5814-58; Laws, 1970, ch. 446, § 8; Laws, 1992, ch. 412, § 4, eff from and after July 1, 1992.**

**Cross References —** Board's powers under (1)(c) and (2) (b) of this section cannot be delegated, see § 83-23-117(4).

Suspension or revocation of certificate of authority to transact insurance for failure to comply with plan of operation, see § 83-23-119.

## JUDICIAL DECISIONS

1. In general.
2. Construction with other laws.

**1. In general.**

Because Miss. Code Ann. § 83-23-123(1) specifically provided that any amount payable by the Mississippi Insurance Guaranty Association (MIGA) on a covered claim would be reduced by the amount of any recovery from an insurance policy other than a policy of an insolvent insurer, MIGA was required to reduce the amount payable to an insured by the amount of his uninsured motorist (UM) carrier's UM payment; assuming the insured's damages amount to be $ 300,000 or more, the amount payable on a covered claim by MIGA would be $ 300,000 because the maximum amount payable by MIGA was $ 300,000 under Miss. Code Ann. § 83-23-115((1)(a)(iii), and that full amount had been discharged by the carrier's payment to the insured. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396 (Miss. 2010).

The Mississippi Insurance Guaranty Association Law (§ 83-23-101 et seq.) requires that the Mississippi Insurance Guaranty Association (MIGA) assume the insurer's duties and obligations, including the duty to defend the insured; thus, MIGA was liable to a claimant for $300,000 of the policy coverage in question-the maximum amount allowed under the Mississippi Insurance Guaranty Law-where MIGA consciously breached its duty by refusing to attend a settlement conference and refusing in any way to defend the claim since MIGA "stepped into the shoes" of the claimant's insolvent insurer and had a duty to either defend the action or pay the policy proceeds to the claimant. Mississippi Ins. Guar. Ass'n v. Byars, 614 So. 2d 959 (Miss. 1993).

While the Mississippi Insurance Guaranty Association (MIGA) is protected by the statutory limitation of $300,000, it is also required by statute to assume the insurer's duties and obligations, which includes the duty to defend the insured. Thus, until MIGA had paid into the court the $300,000, it had a statutory and contractual responsibility to pay or defend. Bobby Kitchens, Inc. v. Mississippi Ins. Guar. Ass'n, 560 So. 2d 129 (Miss. 1989).

This section did not make the state guaranty association the statutory successor of an insolvent insurance company, so as to entitle it to judgment in an interpleader action to determine who was entitled to the proceeds of an agreement of reinsurance; the purpose of this section is to allow the association to assert any defenses on a policy that the insolvent insurer would have been entitled to assert. General Reinsurance Corp. v. Missouri Gen. Ins. Co., 458 F. Supp. 1 (W.D. Mo. 1977), aff'd, 596 F.2d 330 (8th Cir. Mo. 1979).

The Mississippi Insurance Guaranty Association is not in the position to raise the constitutionality of the very statute upon which it depends for its existence. Mississippi Ins. Guar. Ass'n v. Gandy, 289 So. 2d 677 (Miss. 1973).

**2. Construction with other laws.**

Pursuant to Miss. Code Ann. § 82-23-123, a secondary insurer's policy, which contained an other-insurance clause stating that it was in excess to any other primary insurance, was required to be exhausted before the Mississippi Insurance Guaranty Association had a statutory duty under Miss. Code Ann. § 83-23-115(1)(b) to provide coverage under an insolvent carrier's primary policy. Nat'l Union Fire Ins. Co. v. Miss. Ins. Guar. Ass'n, 990 So. 2d 174 (Miss. 2008), remanded by 298 Fed. Appx. 364, 2008 U.S. App. LEXIS 27846 (5th Cir. Miss. 2008).

## RESEARCH REFERENCES

**ALR.** What constitutes "suit" triggering insurer's duty to defend environmental claims—state cases. 48 A.L.R.5th 355.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 67.

## § 83-23-117. Plan of operation.

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

(b) If at any time the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under Section 83-23-115 will be performed.

(b) Establish procedures for handling assets of the association.

(c) Establish the amount and method of reimbursing members of the board of directors under Section 83-23-113.

(d) Establish procedures by which claims may be filed with the association, and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent, and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(e) Establish regular places and times for meetings of the board of directors.

(f) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(g) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision.

(h) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Section 83-23-115(1)(c) and 83-23-115(2)(b), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed, and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a

corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this article.

**SOURCES: Codes, 1942, § 5814-59; Laws, 1970, ch. 446, § 9, eff from and after passage (approved April 6, 1970).**

**RESEARCH REFERENCES**

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-119. Duties and powers of the commissioner.

(1) The commissioner shall:

(a) Notify the association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency.

(b) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may:

(a) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this article. Such notification shall be by mail at their last-known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(b) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due, or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five percent (5%) of the unpaid assessment per month, except that no fine shall be less than One Hundred Dollars ($100.00) per month.

(c) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this article shall be subject to judicial review in a court of competent jurisdiction.

**SOURCES: Codes, 1942, § 5814-60; Laws, 1970, ch. 446, § 10, eff from and after passage (approved April 6, 1970).**

**Cross References** — Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

**RESEARCH REFERENCES**

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 67, 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by

insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

## § 83-23-121. Assignment of rights to association; effect of paid claims.

(1) Any person recovering under this article shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this article shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer, and except as provided in subsection (2). In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person pursuant to this article:

Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article.

(3) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this article against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(4) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent insurer.

**SOURCES: Codes, 1942, § 5814-61; Laws, 1970, ch. 446, § 11; Laws, 1992, ch. 412, § 5, eff from and after July 1, 1992.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 157 et seq.

**CJS.** 44 C.J.S., Insurance § 196.

## § 83-23-123. Nonduplication of recovery.

(1) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer, which is also a

covered claim, shall be required to exhaust first his right under such policy. Any amount payable on a covered claim under this article shall be reduced by the amount of any recovery under such insurance policy.

(2) Any person having a claim which may be recovered under more than one (1) insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and if it is a workmen's compensation claim, he shall seek recovery first from the association of the residence of the claimant. Any recovery under this article shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

**SOURCES: Codes, 1942, § 5814-62; Laws, 1970, ch. 446, § 12, eff from and after passage (approved April 6, 1970).**

## RESEARCH REFERENCES

**ALR.** Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 157 et seq.

**CJS.** 44 C.J.S., Insurance § 196.

## JUDICIAL DECISIONS

1. Liability.
2. Exhaustion requirement.
3. Claim against an insurer.

**1. Liability.**

Because Miss. Code Ann. § 83-23-123(1) specifically provided that any amount payable by the Mississippi Insurance Guaranty Association (MIGA) on a covered claim would be reduced by the amount of any recovery from an insurance policy other than a policy of an insolvent insurer, MIGA was required to reduce the amount payable to an insured by the amount of his uninsured motorist (UM) carrier's UM payment; assuming the insured's damages amount to be $ 300,000 or more, the amount payable on a covered claim by MIGA would be $ 300,000 because the maximum amount payable by MIGA was $ 300,000 under Miss. Code Ann. § 83-23-115((1)(a)(iii), and that full amount had been discharged by the carrier's payment to the insured. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396 (Miss. 2010).

Under Miss. Code Ann. § 83-23-123(2), the Mississippi Insurance Guaranty Association was liable for claims to the reinsurer from nonresident claimants whose policyholders were located in Mississippi at the time of the insured event if those claimants first tried to seek recovery in their home states and were denied; it was clear that the chancellor did not err in his finding because he unquestionably adhered to the statutory scheme of recovery. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865 (Miss. 2006).

**2. Exhaustion requirement.**

Where an injured plaintiff has alternative sources of insurance covering the same claim as the claim against an insolvent insurer, a nonduplication provision in Miss. Code Ann. § 83-23-123 requires the plaintiff to exhaust the solvent policy and deduct the amount recovered from the obligation due by a state insurance guaranty association. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405 (Miss. Ct. App. 2009), affirmed by 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Summary judgment was properly granted to the Mississippi Insurance Guaranty Association because it was entitled to offset an amount recovered by an injured party from its own insurer under

Miss. Code Ann. § 83-23-123 since a covered claim was filed under Miss. Code Ann. § 83-23-109(f) under an uninsured motorist provision. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405 (Miss. Ct. App. 2009), affirmed by 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Because Mississippi Insurance Guaranty Association (MIGA) stepped into the shoes of an insolvent carrier and was bound by the rights, duties, and obligations of the insolvent insurer, it was not entitled to a credit for amounts that the insured received from her employer's uninsured motorist coverage; such recovery was explicitly forbidden under the Mississippi Supreme Court's prior Cossitt decision, and MIGA's contentions that it should be bound only by the exhaustion provision of the Mississippi Insurance Guaranty Association Law were without merit; nothing in the language of Miss. Code Ann. § 83-23-123(1) indicated that the exhaustion provision superseded any other law regarding a carrier's right to recovery. Miss. Ins. Guar. v. Blakeney, 51 So. 3d 208 (Miss. Ct. App. 2009), reversed by 54 So. 3d 203, 2011 Miss. LEXIS 28 (Miss. 2011).

Pursuant to Miss. Code Ann. § 82-23-123, a secondary insurer's policy, which contained an other-insurance clause stating that it was in excess to any other primary insurance, was required to be exhausted before the Mississippi Insurance Guaranty Association had a statutory duty under Miss. Code Ann. § 83-23-115(1)(b) to provide coverage under an insolvent carrier's primary policy. Nat'l Union Fire Ins. Co. v. Miss. Ins. Guar. Ass'n, 990 So. 2d 174 (Miss. 2008), remanded by 298 Fed. Appx. 364, 2008 U.S. App. LEXIS 27846 (5th Cir. Miss. 2008).

Clear and unambiguous reading of the exhaustion provision, Miss. Code Ann. § 83-23-123(1), states that a person who has a covered claim against an insurer under any insurance policy provision must exhaust his other rights under the policy. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407 (Miss. 2007).

**3. Claim against an insurer.**

Insured had a claim against an insurer pursuant to Miss. Code Ann. § 83-23-123(1) because he was covered by an insurance policy that included uninsured motorist coverage; there was no assertion that the uninsured motorist carrier was an insolvent insurer. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396 (Miss. 2010).

## § 83-23-125. Prevention of insolvencies.

To aid in the detection and prevention of insurer insolvencies:

(a) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(b) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination, or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association, and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (c). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(c) It shall be the duty of the commissioner to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(d) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(e) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(f) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the commissioner.

**SOURCES: Codes, 1942, § 5814-63; Laws, 1970, ch. 446, § 13, eff from and after passage (approved April 6, 1970).**

**Cross References —** Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 42 (petition or application for order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form No. 44 (order to show cause why insolvent insurance company should not be liquidated and dissolved and enjoined from transacting business); Form No. 45 (order liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-127. Examination of the association.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

**SOURCES: Codes, 1942, § 5814-64; Laws, 1970, ch. 446, § 14, eff from and after passage (approved April 6, 1970).**

**Cross References** — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance § 96.

## § 83-23-129. Tax exemption.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

**SOURCES: Codes, 1942, § 5814-65; Laws, 1970, ch. 446, § 15, eff from and after passage (approved April 6, 1970).**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 63.

**CJS.** 44 C.J.S., Insurance §§ 118-120.

## § 83-23-131. Recognition of assessments in rates.

The rates and premiums charged for insurance policies to which this article applies may include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

**SOURCES: Codes, 1942, § 5814-66; Laws, 1970, ch. 446, § 16, eff from and after passage (approved April 6, 1970).**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 73.

**CJS.** 44 C.J.S., Insurance §§ 81-83.

## § 83-23-133. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association, its agents or employees, the board of directors, or the commissioner or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this article.

**SOURCES: Codes, 1942, § 5814-67; Laws, 1970, ch. 446, § 17; Laws, 1992, ch. 412, § 6, eff from and after July 1, 1992.**

### JUDICIAL DECISIONS

**1. In general.**

A potential suit against individual agents of the Mississippi Insurance Guaranty Association is acknowledged by statute and not prohibited, if the action in question involves negligence or bad faith. Bobby Kitchens, Inc. v. Mississippi Ins. Guar. Ass'n, 560 So. 2d 129 (Miss. 1989).

### RESEARCH REFERENCES

**ALR.** What constitutes "suit" triggering insurer's duty to defend environmental claims—state cases. 48 A.L.R.5th 355.

## § 83-23-135. Stay of proceedings; access to insolvent insurer's records.

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for six (6) months and for such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured. The association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding, and shall be permitted to defend against such claim on the merits.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this article shall permit access by the board or its authorized representative to the insolvent insurer's records which are necessary for the board in carrying out its functions under this article with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

**SOURCES: Codes, 1942, § 5814-68; Laws, 1970, ch. 446, § 18; Laws, 1992, ch. 412, § 7, eff from and after July 1, 1992.**

### JUDICIAL DECISIONS

**1. In general.**

Where the employee was injured when a forklift struck him in the head at work and landed on top of him, he filed suit against the forklift manufacturer and the retailer for negligence, breach of warranty, and design defect. The trial court granted a motion to stay proceedings filed by the retailer pursuant to Miss. Code Ann. § 83-23-135, because its liability insurer was experiencing financial difficulties and was placed into liquidation; the proceedings were stayed for six months from the date of insolvency. Townsend v. Doosan Infracore Am. Corp., 3 So. 3d 150 (Miss. Ct. App. 2009).

Trial court did not err by denying defendants' claim for a stay on the grounds that its malpractice insurer had been placed in liquidation as the insurer's policy holders were not covered under the Mississippi Insurance Guaranty Association. Byrd v. Bowie, 933 So. 2d 899 (Miss. 2006).

Statute did not provide basis for relief from default judgment where final judgment was entered before defendant's insurance company was adjudicated insolvent, and Circuit Court wholly respected its duty under statute and once 60 day automatic stay expired, court properly took action and denied motion seeking relief from default judgment. H & W Transf. & Cartage Serv., Inc. v. Griffin, 511 So. 2d 895 (Miss. 1987), mandate amended, 534 So. 2d 216 (Miss. 1988).

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-23-137. Proposal for disbursal of assets of insolvent insurer; application for approval.

(1) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by a court of competent jurisdiction, the receiver, liquidator or statutory successor shall make application to the court for approval of a proposal to disburse assets out of such insurer's marshalled assets, from time to time as such assets become available to each association entitled thereto. For the purposes of this section, the term "association" includes the Mississippi Insurance Guaranty Association and any entity or person performing a function in another state similar to that performed in this state by the Mississippi Insurance Guaranty Association, provided the Mississippi Insurance Guaranty Association is entitled to like payment under the laws of the other's state of domicile with respect to insolvent companies doing business in that state.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration, the payment of claims of secured creditors to the extent of the value of the security held, and the payment of claims falling within the priorities established in this article.

(b) Disbursement of the other assets marshalled to date and subsequent disbursements of assets as they become available.

(c) Equitable allocation of disbursements to each association entitled thereto.

(d) The securing by the receiver, liquidator or statutory successor, from each association entitled to disbursements pursuant to this section, of an agreement to return to it such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in this article, in accordance with such priorities; however, no bond shall be required of any such association.

(e) A full report to be made by each association to the receiver, liquidator or statutory successor, which report shall account for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The proposal of the receiver, liquidator or statutory successor shall provide for disbursements to each association in amounts at least equal to the claim payments made, and estimated to be made, by such association for which such association could assert a claim against the receiver, and shall provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made, or to be made, by each such association, then disbursements shall be in the amount of available assets.

(4) Notice of such application shall be given by the receiver, liquidator or statutory successor to the associations in, and to the commissioners of insurance of, each of the states to which disbursement may be made. Such notice shall be made by certified mail, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Such notice shall be deemed to have been made when deposited in the mail.

(5) Action on the application may be taken by the court if notice has been given pursuant to subsection (4) of this section and the proposal of the receiver, liquidator or statutory successor complies with subsection (2) of this section.

**SOURCES: Laws, 1981, ch. 346, § 1, eff from and after passage (approved March 18, 1981).**

## RESEARCH REFERENCES

**ALR.** Validity, construction and effect of Uniform Insurer's Liquidation Act. 46 A.L.R.2d 1185.

## ARTICLE 5.

## MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

SEC.
83-23-201. Citation of article.
83-23-203. Purpose.
83-23-205. Applicability of article.
83-23-207. Construction of article.
83-23-209. Definitions.
83-23-211. Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.
83-23-213. Board of directors; selection; compensation.
83-23-215. Powers of association.
83-23-217. Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.
83-23-218. Member insurers permitted to offset assessment against taxes.
83-23-219. Plan of operation; approval by commissioner; contents of plan.
83-23-221. Duties of commissioner; enforcement of assessments against member insurers; appeal.
83-23-223. Detection and prevention of insurer insolvencies or impairments.

83-23-225. Liability of insolvent or impaired insurer for assessments.
83-23-227. Regulation by commissioner; annual report.
83-23-229. Tax status of association.
83-23-231. Immunity of member insurers, employees, directors of association and similar organizations.
83-23-233. Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.
83-23-235. Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.

## § 83-23-201. Citation of article.

This article shall be known and may be cited as the "Mississippi Life and Health Insurance Guaranty Association Act".

**SOURCES: Laws, 1985, ch. 482, § 1, eff from and after passage (approved April 9, 1985).**

**Cross References —** Mississippi Insurance Guaranty Association Law, see §§ 83-23-101 et seq.

### RESEARCH REFERENCES

**Practice References.** Thomas, Jeffrey E., Martinez, Leo P., Mayerson, Marc S., and Richmond, Douglas R., 2011 Edition of New Appleman Insurance Law Practice Guide.

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-203. Purpose.

(1) The purpose of this article is to protect, subject to certain limitations, the persons specified in Section 83-23-205(1) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in Section 83-23-205(2), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

**SOURCES: Laws, 1985, ch. 482, § 2; Laws, 1990, ch. 546, § 1, eff from and after July 1, 1990.**

**Cross References —** Liberal construction of article to effectuate legislative purpose, see § 83-23-207.

### JUDICIAL DECISIONS

**1. In general.**

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233 (Miss. 2007).

Purpose of the Mississippi Life and Health Guaranty Association is not to give claimants more than they would have received had the insurer with which they dealt been held directly accountable for the amounts owed rather than sheltered by the tent of bankruptcy proceedings. Bank of Miss. v. Miss. Life & Health Ins. Guar. Ass'n, 850 So. 2d 127 (Miss. Ct. App. 2003).

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-205. Applicability of article.

(1) This article shall provide coverage for the policies and contracts specified in subsection (2)(a) of this section:

(a) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under paragraph (b);

(b) To persons who are owners of or certificate holders under the policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this article;

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(c) For unallocated annuity contracts specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to:

(i) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(d) For structured settlement annuities specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(i) Is a resident, regardless of where the contract owner resides, or

(ii) Is not a resident, but only under both of the following conditions:

1.a. The contract owner of the structured settlement annuity is a resident, or

b. The contract owner of the structured settlement annuity is not a resident, but (1) the insurer that issued the structured settlement annuity is domiciled in this state; and (2) the state in which the contract owner resides has an association similar to the association created by this article; and

2. Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(e) This article shall not provide coverage to:

(i) A person who is a payee (or beneficiary) or a contract owner resident of this state, if the payee (or beneficiary) is afforded any coverage by the association of another state; or

(ii) A person covered under paragraph (c) of this subsection, if any coverage is provided by the association of another state to the person.

(f) This article is intended to provide coverage to a person who is a resident of this state and in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article is provided coverage under the laws of any other state, the person shall not be provided coverage under this article. In determining the application of the provisions of this paragraph, in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, this article shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) This article shall provide coverage to the persons specified in subsection (1) of this section for direct, nongroup life, health, or annuity policies or contracts and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(b) This article shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based:

1. Averaged over the period of four (4) years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the association became obligated; and

2. On and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

1. A Multiple Employer Welfare Arrangement as defined in 29 USCS Section 1144;

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by Section 83-23-217 with respect to the policy or contract are preempted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;

2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

3. Misrepresentations of or regarding policy benefits;

4. Extra-contractual claims; or

5. A claim for penalties or consequential or incidental damages; and

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to any one (1) life, regardless of the number of policies or contracts:

1. Three Hundred Thousand Dollars ($300,000.00) in life insurance death benefits, but not more than One Hundred Thousand Dollars ($100,000.00) in net cash surrender and net cash withdrawal values for life insurance;

2. In health insurance benefits:

a. One Hundred Thousand Dollars ($100,000.00) for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance, including any net cash surrender and net cash withdrawal values;

b. Three Hundred Thousand Dollars ($300,000.00) for disability insurance;

c. Five Hundred Thousand Dollars ($500,000.00) for basic hospital medical and surgical insurance or major medical insurance; or

3. One Hundred Thousand Dollars ($100,000.00) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) With respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, One Hundred Thousand Dollars ($100,000.00) in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), One Hundred Thousand Dollars ($100,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) However, in no event shall the association be obligated to cover more than (a) an aggregate of Three Hundred Thousand Dollars ($300,000.00) in benefits with respect to any one (1) life under paragraphs (b)(i), (b)(ii) and (b)(iii) of this subsection except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance under paragraph (b)(i) of this subsection, in which case the aggregate liability of the association shall not exceed Five Hundred Thousand Dollars ($500,000.00) with respect to any one (1) individual, or (b) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than Five Million Dollars ($5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either (a) one (1) contract owner provided coverage under subsection (1)(c)(ii) of this section; or (b) one (1) plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph (b)(ii) of this subsection, Five Million Dollars ($5,000,000.00) in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this article and are owned by a trust or other entity for the benefit of two (2) or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than Five Million Dollars ($5,000,000.00) in benefits with respect to all these unallocated contracts.

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this article may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(4) In performing its obligations to provide coverage under Section 83-23-215, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the

contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

**SOURCES: Laws, 1985, ch. 482, § 3; Laws, 1990, ch. 546, § 2; Laws, 1999, ch. 365, § 1, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Insurance guaranty association for other kinds of insurance, see §§ 83-23-101 et seq.

Purpose of this article, see § 83-23-203.

Definition of "covered policy" and "member insurer," see § 83-23-209.

For definitions applicable to this article, see § 83-23-209.

Powers of Mississippi Life and Health Insurance Guaranty Association, see § 83-23-215.

**Federal Aspects —** Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457.

Definition of Multiple Employer Welfare Arrangement, 29 USCS § 1002.

Federal Pension Benefit Guaranty Corporation, 29 USCS §§ 1301 et seq.

### JUDICIAL DECISIONS

1. Interest rates.
2. Liability for misrepresentation.

**1. Interest rates.**

Where the liquidator of an insolvent insurer provided a replacement annuity to the trust set up for the beneficiaries of the original annuity, and the trust sued the Mississippi Life and Health Guaranty Association to recover the beneficiaries' losses, the circuit court correctly applied the interest rates provided in the substitute annuity in calculating damages owed by the Association, because to use any others would have given the trust a windfall to the detriment of the general public. Bank of Miss. v. Miss. Life & Health Ins. Guar. Ass'n, 850 So. 2d 127 (Miss. Ct. App. 2003).

**2. Liability for misrepresentation.**

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233 (Miss. 2007).

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-207. Construction of article.

This article shall be construed to effect the purpose under Section 85-23-203.

**SOURCES: Laws, 1985, ch. 482, § 4; Laws, 1999, ch. 365, § 2, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Statement of legislative intent, see § 83-23-203.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-209. Definitions.

As used in this article:

(a) "Account" means either of the two (2) accounts created under Section 83-23-211.

(b) "Association" means the Mississippi Life and Health Insurance Guaranty Association created under Section 83-23-211.

(c) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(d) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(e) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 83-23-205.

(h) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 83-23-205.

(i) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

(j) "Impaired insurer" means a member insurer which, after April 9, 1985, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(k) "Insolvent insurer" means a member insurer which after April 9, 1985, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(*l*) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 83-23-205, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A hospital or medical service organization whether profit or nonprofit;

(ii) A health maintenance organization;

(iii) A fraternal benefit society;

(iv) A mandatory state pooling plan;

(v) A mutual assessment company or other person that operates on an assessment basis;

(vi) An insurance exchange; or

(vii) Any entity similar to any of the above.

(m) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(n) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(o) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(p) "Plan sponsor" means:

(i) The employer in the case of a benefit plan established or maintained by a single employer;

(ii) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(iii) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(q) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits, and less dividends and experience credits. "Premiums" does not include any amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 83-23-205(2), except that assessable premium shall not be reduced on account of Sections 83-23-205(2)(b)(iii) relating to interest limitations and 83-23-205(3)(b) relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(i) Premiums in excess of Five Million Dollars ($5,000,000.00) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

(ii) With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of Five Million Dollars ($5,000,000.00) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(r) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan described in paragraph (p)(iii) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(s) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(t) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(v) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(w) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(x) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

**SOURCES: Laws, 1985, ch. 482, § 5; Laws, 1990, ch. 546, § 3; Laws, 1999, ch. 365, § 3, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References** — Scope of article, see § 83-23-205.

Association and its accounts, see § 83-23-211.

Computation of assessments against member insurers, see § 83-23-217.

**Federal Aspects** — Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457.

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-211. Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.

(1) There is created a nonprofit legal entity to be known as the Mississippi Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to

transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 83-23-219 and shall exercise its powers through a board of directors established under Section 83-23-213. For purposes of administration and assessment the association shall maintain two (2) accounts:

(a) The life insurance and annuity account which includes the following subaccounts:

(i) Life insurance account;

(ii) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(iii) Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(b) The health insurance account.

(2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

**SOURCES: Laws, 1985, ch. 482, § 6; Laws, 1990, ch. 546, § 4; Laws, 1999, ch. 365, § 4, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Definition of "account" and "association," see § 83-23-209.

Board of directors of association, see § 83-23-213.

Association's plan of operation, see § 83-23-219.

Tax status of association, see § 83-23-229.

**Federal Aspects —** Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457.

## JUDICIAL DECISIONS

**1. In general.**

Mississippi Life and Health Insurance Guaranty Association is liable to insured covered by insolvent health insurer only for contractual obligation of insurer, not for attorney fees and punitive damages included in default judgment against insolvent insurer. Rowley v. First Columbia Life Ins., 741 F. Supp. 1259 (S.D. Miss. 1989).

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-213. Board of directors; selection; compensation.

(1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members.

(2) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

**SOURCES: Laws, 1985, ch. 482, § 7, eff from and after passage (approved April 9, 1985).**

**Cross References** — Performance of association's functions through board of directors, see § 83-23-211.

Requirement that plan of operation contain method for reimbursing directors, see § 83-23-219.

Duties of commissioner, see § 83-23-221.

Relationship between board of directors and commissioner in detecting and preventing insolvency or impairment among member insurers, see § 83-23-223.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-215. Powers of association.

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not

impair the contractual obligations of the impaired insurer, and that are approved by the commissioner:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the policies or contracts of the impaired insurer; or

(b) Provide such monies, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a), and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a).

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide monies, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to nongroup policies, contracts and annuities not later than the earlier of the next renewal date (if any) under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants (for nongroup policies and contracts), or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination (pursuant to subparagraph (i) of this paragraph) of the benefits provided;

(iii) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured, or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(iv)1. In providing the substitute coverage required under subparagraph (iii), the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy;

3. The association may reinsure any alternative or reissued policy.

(v)1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten;

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under subsection (2) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 83-23-205(2)(b)(iii).

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this article with respect to the policy or coverage, except with respect to any claims incurred or any net cash

surrender value which may be due in accordance with the provisions of this article.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(5) The protection provided by this article shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for a period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to Section 83-24-103 of the Insurers Rehabilitation and Liquidation Act, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and retained pursuant to this subsection. Any amount so paid to the association less the amount retained by

it shall be treated as a distribution of estate assets pursuant to Section 83-24-67 of the Insurers Rehabilitation and Liquidation Act or similar provision of the state of domicile of the impaired or insolvent insurer.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this article with respect to the insolvent insurer.

(9) The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.

(c) In addition to paragraphs (a) and (b) above, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to such policy or contracts (including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor), excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies (or portion thereof) covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies (or portion thereof) covered by the association.

(12) In addition to the rights and power elsewhere in this article, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 83-23-217 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this article;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this article;

(g) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

(13) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14)(a) At any time within one (1) year after the date on which the association becomes responsible for the obligations of a member insurer (the coverage date), the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts covered (in whole or in part) by the association, under any one (1) or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurers. If the association makes an election, subparagraphs (i) through (iv) below shall apply with respect to the agreements selected by the association:

(i) The association shall be responsible for all unpaid premiums due under the agreements (for periods both before and after the coverage date), and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered (in whole or in part) by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;

(ii) The association shall be entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association (in whole or in part), provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of:

1. The amount received by the association, over

2. The benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event;

(iii) Within thirty (30) days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer (or its receiver, rehabilitator or liquidator) or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within five (5) days of the completion of the aforementioned calculation. If the receiver, rehabilitator or liquidator has received any amounts due the association pursuant to subparagraph (ii), the receiver, rehabilitator or liquidator shall remit the same to the association as promptly as practicable;

(iv) If the association, within sixty (60) days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association (in whole or in part), the reinsurer shall not be entitled to terminate the reinsurance agreements (insofar as the agreements) relate to contracts covered by the association (in whole or in part) and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(b) In the event the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under paragraph (a) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to above in paragraph (a) provided that:

(i) The indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(ii) The obligations described in the proviso to paragraph (a)(ii) of this subsection shall no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer; and

(iii) This paragraph (b) shall not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in paragraph (a);

(c) The provisions of this subsection shall supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator or rehabilitator of the insolvent member insurer. The receiver, rehabilitator or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date (subject to applicable setoff provisions); and

(d) Except as otherwise expressly provided above, nothing herein shall alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing herein shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing herein shall give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

(15) The board of directors of the association shall have discretion and may exercise a reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under the article shall be in Hinds County, Mississippi. The association shall not be required to give

an appeal bond in an appeal that relates to a cause of action arising under this article.

**SOURCES: Laws, 1985, ch. 482, § 8; Laws, 1990, ch. 546, § 5; Laws, 1999, ch. 365, § 5, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Insolvent insurance companies, see §§ 83-23-1 et seq.

Definition of "impaired insurer," see § 83-23-209.

Assessments against member insurers, see § 83-23-217.

Use of class "B" assessments to carry out duties of association with respect to impaired or insolvent insurers, see § 83-23-217.

Association's plan of operation, see § 83-23-219.

Duties of commissioner, see § 83-23-221.

Reduction in liability of insolvent insurer to association by amount to which association is entitled as subrogee under § 83-23-215, see § 83-23-225.

Requirement that records be kept of negotiations between association and insolvent or impaired insurers, see § 83-23-225.

Annual report by association, see § 83-23-227.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Entitlement of association to stay of actions involving insolvent insurers, see § 83-23-233.

**Federal Aspects —** Sections 130 of the Internal Revenue Code, see 26 USCS § 130.

## JUDICIAL DECISIONS

**1. In general.**

Mississippi Life and Health Insurance Guaranty Association is liable to insured covered by insolvent health insurer only for contractual obligation of insurer, not for attorney fees and punitive damages included in default judgment against insolvent insurer. Rowley v. First Columbia Life Ins., 741 F. Supp. 1259 (S.D. Miss. 1989).

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-217. Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments, as follows:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 83-23-215 with regard to an impaired or insolvent insurer.

(3)(a) The amount of any Class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all nonpro rata assessments shall not exceed One Hundred Fifty Dollars ($150.00) per member insurer in any one (1) calendar year. The amount of a Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (2) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) Subject to the provisions of subparagraph (ii) of this paragraph, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in any one (1) calendar year exceed two percent (2%) of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two (2) or more assessments are authorized in one (1) calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (i) of this paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (3)(b) of this section, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (5)(a) above.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article.

(8) The association shall issue to each insurer paying an assessment under this article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the

assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

**SOURCES: Laws, 1985, ch. 482, § 9; Laws, 1990, ch. 546, § 6; Laws, 1999, ch. 365, § 6, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Definition of "premiums" see § 83-23-209.
Association's duties with respect to impaired or insolvent insurers, see § 83-23-215.
Offset of assessment amounts against taxes, see § 83-23-218.
Association's plan of operation, see § 83-23-219.
Duties of commissioner, see § 83-23-221.
Examinations conducted by association to prevent insolvencies, see § 83-23-223.
Liability of insolvent or impaired insurer for assessments, see § 83-23-225.

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-218. Member insurers permitted to offset assessment against taxes.

(1) From and after July 1, 1993, a member insurer may offset against its (premium, franchise or income) tax liability (or liabilities) to this state an assessment described in Section 83-23-217(8) to the extent of twenty percent (20%) of the amount of such assessment, if any, for each year over the next five (5) succeeding years. However, if the offset is less than twenty percent (20%), any unused balance may be carried over to any succeeding year until such time as the offset provided herein is fully used. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its (premium, franchise or income) tax liability (or liabilities) for the year it ceases doing business.

(2) Any sums which are acquired by refund, pursuant to Section 83-23-217(6), from the association by member insurers, and which have theretofore been offset against (premium, franchise or income) taxes as provided in subsection (1) of this section, shall be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

**SOURCES: Laws, 1990, ch. 546, § 11; Laws, 1993, ch. 347, § 1, eff from and after July 1, 1993.**

## § 83-23-219. Plan of operation; approval by commissioner; contents of plan.

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he has not disapproved it within thirty (30) days.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days following April 9, 1985, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this article:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under Section 83-23-213;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under Section 83-23-217;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Sections 83-23-215 and 83-23-217, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

**SOURCES: Laws, 1985, ch. 482, § 10; Laws, 1990, ch. 546, § 7, eff from and after July 1, 1990.**

**Cross References —** Requirement that association perform its functions under plan of operation, see § 83-23-211.

Board of directors of association, see § 83-23-213.

Powers of association, see § 83-23-215.

Assessments, see § 83-23-217.

Duties of commissioner, see § 83-23-221.

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-221. Duties of commissioner; enforcement of assessments against member insurers; appeal.

(1) In addition to the duties and powers enumerated elsewhere in this article, the commissioner shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this article;

(c) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars ($100.00) per month.

(3) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within thirty (30) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(4) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this article.

**SOURCES: Laws, 1985, ch. 482, § 11; Laws, 1990, ch. 546, § 8; Laws, 1999, ch. 365, § 7, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

Commissioner's duties with respect to insolvent insurers, see §§ 83-23-1 et seq.

Commissioner's approval of members of board of directors, see § 83-23-213.

Commissioner's approval of plans to guaranty obligations of impaired or insolvent insurers, see § 83-23-215.

Commissioner's approval of member insurer's method of carrying assessment on its financial statements, see § 83-23-217.

Notice by commissioner of actions against member insurers, see § 83-23-223.

Examination by commissioner of association, see § 83-23-227.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-223. Detection and prevention of insurer insolvencies or impairments.

To aid in the detection and prevention of insurer insolvencies or impairments:

(1) It shall be the duty of the commissioner;

(a) To notify the commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

(iii) Makes a formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policy owners or creditors.

(b) To report to the board of directors when the commissioner has taken any of the actions set forth in (a) of this paragraph or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) To furnish to the board of directors the NAIC IRIS ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

**SOURCES: Laws, 1985, ch. 482, § 12; Laws, 1999, ch. 365, § 8, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Board of directors, see § 83-23-213.

Fund to be used for costs of examination of member insurer, see § 83-23-217.

Duties of commissioner, generally, see § 83-23-221.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-225. Liability of insolvent or impaired insurer for assessments.

(1) This article shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 83-23-215. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under Section 83-23-227.

(3) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts

to which the association is entitled as subrogee pursuant to Section 83-23-215(11). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section and consistent with Section 83-24-67, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this article. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Section 83-23-215 with respect to such insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) through (d).

(b) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

**SOURCES: Laws, 1985, ch. 482, § 13; Laws, 1990, ch. 546, § 9; Laws, 1999, ch. 365, § 9, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References** — Powers of association, see § 83-23-215.
Assessments by association, see § 83-23-217.
Annual report of association's activities, see § 83-23-227.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-227. Regulation by commissioner; annual report.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.

**SOURCES: Laws, 1985, ch. 482, § 14, eff from and after passage (approved April 9, 1985).**

**Cross References** — Powers of association, see § 83-23-215.
Duties of commissioner, see § 83-23-221.
Records of negotiations with insolvent or impaired insurers, see § 83-23-225.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-229. Tax status of association.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

**SOURCES: Laws, 1985, ch. 482, § 15, eff from and after passage (approved April 9, 1985).**

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-231. Immunity of member insurers, employees, directors of association and similar organizations.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this article. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

**SOURCES: Laws, 1985, ch. 482, § 16; Laws, 1990, ch. 546, § 10, eff from and after July 1, 1990.**

### JUDICIAL DECISIONS

1-2. [Reserved for future use.]
3. Liability for misrepresentation.

**1-2. [Reserved for future use.]**

**3. Liability for misrepresentation.**

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233 (Miss. 2007).

RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-233. Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers and duties. As to judgment under any decision, order, verdict or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

**SOURCES: Laws, 1985, ch. 482, § 17, eff from and after passage (approved April 9, 1985).**

**Cross References** — Proceedings involving insolvent insurance companies, see §§ 83-23-1 et seq.

Powers of association, see § 83-23-215.

RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

## § 83-23-235. Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.

(1) No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Mississippi Life and Health Insurance Guaranty Association Act. However, this section shall not apply to

the Mississippi Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

(2) Within one hundred eighty (180) days of April 9, 1985, the association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subsection (3) of this section. This document shall be submitted to the commissioner for approval. At the expiration of the sixtieth day after the date on which the commissioner approves the document, an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder or insured any greater rights than those stated in this article.

(3) The document prepared under subsection (2) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

(a) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(b) Prominently warn the policy or contract owner that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State the types of policies for which guaranty funds will provide coverage;

(d) State that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(e) State that the policy or contract owner should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer;

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this article; and

(g) Provide other information as directed by the commissioner including, but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

(4) A member insurer shall retain evidence of compliance with subsection (2) for so long as the policy or contract for which the notice is given remains in effect.

**SOURCES: Laws, 1985, ch. 482, § 18; Laws, 1999, ch. 365, § 10, eff from and after passage (approved Mar. 15, 1999.)**

**Cross References —** Unfair deceptive insurance practices, see § 83-5-35.

## RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 115 et seq.

**CJS.** 44 C.J.S., Insurance § 197.

# CHAPTER 24

## Insurers Rehabilitation and Liquidation Act

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83-24-79. Failure of secured creditor to file claim; distribution on claim.
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83-24-83. Priority of distribution of claims; order of distribution.
83-24-85. Review of claims filed in liquidation; reports; power and duty of court.
83-24-87. Payment of distributions.
83-24-89. Deposit of unpaid funds with State Treasurer; escheat proceedings.
83-24-91. Application for order of discharge; costs and expenses.
83-24-93. Reopening proceedings after discharge of liquidator; orders.
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83-24-97. Audit of books of commissioner relating to receivership established under this chapter; reports; expenses.
83-24-99. Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator; orders.
83-24-101. Application by commissioner for order permitting liquidation of assets found in state of foreign insurer or alien insurer not domiciled in state; notice; filing or recording order; domiciliary liquidator appointed in reciprocal state or nonreciprocal state; payment of claims.
83-24-103. Vesting of title to assets in liquidator; filing claim with liquidator or ancillary receiver.
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83-24-109. Claimants residing in foreign country or in states not reciprocal states; time requirements; notice; claims by claimants residing in reciprocal states.
83-24-111. Liquidation proceeding in reciprocal state against insurer domiciled in that state; claims by residents of Mississippi; notice; hearings; final allowance.
83-24-113. Attachment, garnishment or levy of execution against delinquent insurer during pendency of liquidation proceedings.
83-24-115. Liquidation proceeding in Mississippi involving one or more reciprocal states; order of distribution; priority of claims; special deposit claims; surrender of secured claim.
83-24-117. Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator.

## § 83-24-1. Short title.

This chapter shall be cited as the Insurers Rehabilitation and Liquidation Act.

**SOURCES: Laws, 1991, ch. 417, § 1, eff from and after passage (approved March 20, 1991).**

**Cross References —** Maintenance of civil action for damages for benefit of insurer, if order for liquidation or rehabilitation of controlled insurer entered in accordance with this (Insurers Rehabilitation and Liquidation) Act, see § 83-59-11.

### RESEARCH REFERENCES

**ALR.** Validity, construction, and application of Uniform Insurers Liquidation Act. 44 A.L.R.5th 683.

## § 83-24-3. Declaration of purpose.

The purpose of this chapter is the protection of the interests of insureds, claimants, creditors and the public generally; with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(a) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

(b) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(c) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(d) Equitable apportionment of any unavoidable loss;

(e) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(f) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business; and

(g) Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this chapter as part of the regulation of the business of insurance, insurance industry and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

**SOURCES: Laws, 1991, ch. 417, § 2, eff from and after passage (approved March 20, 1991).**

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 93-118 (insolvency, dissolution, and rehabilitation).

14 Am. Jur. Pl & Pr Forms (Rev), Insolvency, Form 1.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42.

10 Am. Jur. Legal Forms 2d, Insolvency § 148:1.

3 Am. Jur. Trials 681, Tactics and Strategy of Pleading.

6 Am. Jur. Proof of Facts 367, Insolvency, Proof 2.

**CJS.** 44 C.J.S., Insurance §§ 181-197.

## § 83-24-5. Application of chapter.

The proceedings authorized by this chapter may be applied to:

(a) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

(b) All insurers who purport to do an insurance business in this state.

(c) All insurers who have insureds residing in this state.

(d) All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

(e) All nonprofit service plans and all fraternal benefit societies and beneficial societies.

(f) All title insurance companies.

(g) All prepaid health care delivery plans.

(h) All corporate bodies organized for the purpose of carrying on the business of mutual insurance subject to the provisions of Section 83-31-1 et seq.

(i) All health maintenance organizations established under Section 41-7-401.

**SOURCES: Laws, 1991, ch. 417, § 3; Laws, 1994, ch. 422, § 2; Laws, 1997, ch. 307, § 5, eff from and after July 1, 1997.**

**Editor's Note** — Section 41-7-401 referred to in (i) was repealed by Laws of 1998, ch. 613, § 35, eff from and after July 1, 1995. For similar provisions, see §§ 83-41-301 et seq.

**Cross References** — "Doing business" defined, see § 83-24-7.

Fraternal benefit societies defined, see § 83-29-1.

Applicability of this chapter to health maintenance organizations, see § 83-41-341.

## § 83-24-7. Definitions.

For the purposes of this chapter:

(a) "Ancillary state" means any state other than a domiciliary state.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

(d) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under Section 83-24-19. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(e) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(i) The issuance or delivery of contracts of insurance to persons residing in this state;

(ii) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(iii) The collection of premiums, membership fees, assessments or other consideration for such contracts;

(iv) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(v) Operating under a license or certificate of authority, as an insurer, issued by the Department of Insurance.

(f) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(g) "Fair consideration" is given for property or obligation:

(i) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(ii) When such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(h) "Foreign country" means any other jurisdiction not in any state.

(i) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(j) "Guaranty association" means the Mississippi Insurance Guaranty Association Law, as amended, the Mississippi Life and Health Insurance Guaranty Association Act, as amended, and any other similar entity now or hereafter created by the Legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(k) "Insolvency" or "insolvent" means:

(i) For an insurer issuing only assessable fire insurance policies:

(A) The inability to pay any obligation within thirty (30) days after it becomes payable; or

(B) If an assessment be made within thirty (30) days after such date, the inability to pay such obligation thirty (30) days following the date specified in the first assessment notice issued after the date of loss.

(ii) For any other insurer, that the insurer is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(A) Any capital and surplus required by law for its organization; or

(B) The total par or stated value of its authorized and issued capital stock.

(iii) As to any insurer licensed to do business in this state as of March 20, 1991, which does not meet the standard established under subparagraph (ii), the term "insolvency" or "insolvent" shall mean for a period not to exceed three (3) years from March 20, 1991, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law.

(iv) For purposes of this subsection, "liabilities" shall include but not be limited to reserves required by statute or by insurance department general regulations or specific requirements imposed by the commissioner upon a subject company.

(*l*) "Insurer" means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance commissioner. For purposes of this chapter, any other persons included under Section 83-24-5 shall be deemed to be insurers.

(m) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(n) "Receiver" means receiver, liquidator, rehabilitator or conservator as the context requires.

(o) "Reciprocal state" means any state other than this state in which in substance and effect Sections 83-24-35, 83-24-103, 83-24-105, 83-24-109, 83-24-111 and 83-24-113 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(p) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(q) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(r) "State" means any state, district or territory of the United States and the Panama Canal Zone.

(s) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

**SOURCES: Laws, 1991, ch. 417, § 4, eff from and after passage (approved March 20, 1991).**

**Cross References** — Mississippi Insurance Guaranty Association Law, see §§ 83-23-101 et seq.

Mississippi Life and Health Insurance Guaranty Association Act, see §§ 83-23-201 et seq.

## § 83-24-9. Commencement of delinquency proceedings; jurisdiction.

(1) No delinquency proceeding shall be commenced under this chapter by anyone other than the commissioner and no court shall have jurisdiction to entertain, hear or determine any proceeding commenced by any other person.

(2) No court shall have jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter.

(3) In addition to other grounds for jurisdiction provided by the law of this state, a court having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Mississippi Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(b) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(c) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(d) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(e) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(5) All action herein authorized shall be brought in the Chancery Court of the First Judicial District of Hinds County.

**SOURCES: Laws, 1991, ch. 417, § 5, eff from and after passage (approved March 20, 1991).**

## § 83-24-11. Injunctions and orders; application.

(1) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(a) The transaction of further business;

(b) The transfer of property;

(c) Interference with the receiver or with a proceeding under this chapter;

(d) Waste of the insurer's assets;

(e) Dissipation and transfer of bank accounts;

(f) The institution or further prosecution of any actions or proceedings;

(g) The obtaining of preferences, judgments, attachments, garnishments or liens against the insurer, its assets or its policyholders;

(h) The levying of execution against the insurer, its assets or its policyholders;

(i) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(j) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(k) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors or shareholders, or the administration of any proceeding under this chapter.

(2) The receiver may apply to any court outside of the state for the relief described in subsection (1).

**SOURCES: Laws, 1991, ch. 417, § 6, eff from and after passage (approved March 20, 1991).**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 93, 94 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42 (petition or application for

order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form 44 (order to show cause why insolvent insurance company should not be liquidated and dissolved and enjoined from transacting business); Form 45 (order liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

**CJS.** 44 C.J.S., Insurance § 194.

## § 83-24-13. Cooperation with Commissioner of Insurance; penalty for obstructing or interfering with proceedings; hearings.

(1) Any officer, manager, director, trustee, owner, employee or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under this chapter or any investigation preliminary to the proceeding. The term "person" as used in this section shall include any person who exercises control, directly or indirectly, over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(b) To make available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody or control.

(2) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(4) Any person included within subsection (1) who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the commissioner issued validly under this chapter, may:

(a) Be sentenced to pay a fine not exceeding Ten Thousand Dollars ($10,000.00) or to undergo imprisonment for a term of not more than one (1) year, or both; or

(b) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) and shall be subject further to the revocation or suspension of any insurance licenses issued by the commissioner.

**SOURCES: Laws, 1991, ch. 417, § 7, eff from and after passage (approved March 20, 1991).**

**Cross References** — Definitions, generally, see § 83-24-7.

Notice of liquidation as affecting duties of agent of insurer, see § 83-24-45.

RESEARCH REFERENCES

**Am Jur.** 1A Am. Jur. Pl & Pr Forms (Rev), Administrative Law, Form 341.2 (complaint, petition, or declaration — by license holder — against administrative agency — to enjoin further proceedings to suspend or revoke license — attempt to suspend or revoke license on grounds not listed in statute authorizing suspension or revocation of license).

## § 83-24-15. Commencement of proceedings under former law; application of current provisions.

Every proceeding commenced under the laws in effect before the enactment of this chapter shall be deemed to have commenced under this chapter for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this chapter not been enacted.

**SOURCES: Laws, 1991, ch. 417, § 8, eff from and after passage (approved March 20, 1991).**

**Editor's Note —** This chapter was enacted by Chapter 417, Laws of 1991, effective from and after March 20, 1991.

## § 83-24-17. Restrictions on insurer after commencement of delinquency proceedings.

No insurer that is subject to any delinquency proceedings, whether formal or informal (administrative or judicial), shall:

(a) Be released from such proceeding unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(b) Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(c) Be returned to the control of its shareholders or private management; or

(d) Have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

**SOURCES: Laws, 1991, ch. 417, § 9, eff from and after passage (approved March 20, 1991).**

## § 83-24-19. Petition for court order for formal delinquency proceeding; content of order; ex parte order; duration of order; affect on contractual obligations; hearings; review of order; notice.

(1) The commissioner may file in the chancery court a petition alleging, with respect to a domestic insurer:

(a) That there exists any grounds that would justify a court order for a formal delinquency proceeding against an insurer under this chapter;

(b) That the interests of policyholders, creditors or the public will be endangered by delay; and

(c) The contents of an order deemed necessary by the commissioner.

(2) Upon a filing under subsection (1), the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter shall ipso facto vacate the seizure order.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen (15) days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

**SOURCES: Laws, 1991, ch. 417, § 10, eff from and after passage (approved March 20, 1991).**

**Cross References —** Delinquency proceeding, defined, see § 83-24-7.
Confidentiality of records, see § 83-24-21.
Discretion of commissioner of insurance to institute proceedings, see § 83-24-107.

## § 83-24-21. Confidentiality of records pertaining to proceedings.

In all proceedings and judicial reviews under Section 83-24-19, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the chancery court, after hearing arguments from the parties in chambers, shall order otherwise; or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the chancery court shall be held by him in a confidential file.

**SOURCES: Laws, 1991, ch. 417, § 11, eff from and after passage (approved March 20, 1991).**

**Cross References —** Discretion of commissioner of insurance to institute proceedings, see § 83-24-107.

## § 83-24-23. Petition for order to rehabilitate domestic insurer or alien insurer domiciled in state; grounds.

The commissioner may apply by petition to the chancery court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(a) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors or the public.

(b) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(c) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(d) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(e) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere; and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(f) After demand by the commissioner under Section 83-1-31, Mississippi Code of 1972, or under this chapter, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(g) Without first obtaining the written consent of the commissioner, the insurer has transferred or attempted to transfer, in a manner contrary to Sections 83-6-1 through 83-6-43, or 83-19-71, Mississippi Code of 1972, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person.

(h) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this chapter.

(i) Within the previous four (4) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner.

(j) The insurer has failed to pay within sixty (60) days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(k) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation immediately.

(*l*) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities request or consent to rehabilitation under this chapter.

**SOURCES: Laws, 1991, ch. 417, § 12, eff from and after passage (approved March 20, 1991).**

**Editor's Note —** Section 83-19-71 referred to in (g) was repealed by Laws of 1991, ch. 501, § 6, eff from and after July 1, 1991. For similar provisions, see §§ 83-19-151 et seq.

**Cross References —** Restoration of insurer's interest, see § 83-24-31.

Petition for order directing liquidation, see § 83-24-33.

Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

### RESEARCH REFERENCES

**ALR.** Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 93-118 (insolvency, dissolution, and rehabilitation).

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42 (petition or application for order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form 44 (order to show cause why insolvent insurance company should not be liquidated and dissolved and enjoined from transacting business); Form 45 (order for liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

**CJS.** 44 C.J.S., Insurance §§ 181-197.

## § 83-24-25. Rehabilitator designated; affect of order of rehabilitation; affect on contractual obligations.

(1) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that clerk would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accountings to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan will be prepared by the rehabilitator and the timetable for doing so.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to Section 83-24-27.

**SOURCES: Laws, 1991, ch. 417, § 13, eff from and after passage (approved March 20, 1991).**

**Cross References —** Claims made under employment contracts by directors, principal officers, or persons performing similar functions, see § 83-24-73.

## § 83-24-27. Appointment of special deputies; powers and duties; compensation; counsel; clerical assistants; advisory committee of policyholders, claimants, or other creditors; cost of administration; implementation of legal proceedings; plans for reorganization, etc.; fraudulent transfers.

(1) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. The commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in rehabilitation proceedings conducted under this chapter.

(2) In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available money of the insurer.

(3) The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(4) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(5) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer is

appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(6) The rehabilitator shall have the power under Sections 83-24-51 and 83-24-53 to avoid fraudulent transfers.

**SOURCES: Laws, 1991, ch. 417, § 14, eff from and after passage (approved March 20, 1991).**

**Cross References** — Restoration of insurer's interest, see § 83-24-31.

**RESEARCH REFERENCES**

**ALR.** Negligent discharge of employee. 53 A.L.R.5th 219.

## § 83-24-29. Stay of action or proceeding; statute of limitations; defense of laches; standing to appear in proceedings.

(1) Any court in this state before which any action or proceeding is pending in which the insurer is a party or is obligated to defend a party when a rehabilitation order against the insurer is entered, shall stay the action or proceeding for ninety (90) days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one (1) year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the

period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

(3) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

**SOURCES: Laws, 1991, ch. 417, § 15, eff from and after passage (approved March 20, 1991).**

## § 83-24-31. Petition for order of liquidation; order of liquidation on grounds of insolvency; petition for order terminating rehabilitation of insurer; restoration of insurer's interest.

(1) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the commissioner may petition the court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under Section 83-24-33. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The protection of the interests of insureds, claimants and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six (6) months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under Section 83-24-27, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(3) The rehabilitator may at any time petition the court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Section 83-24-23 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The court may also make that finding and issue that order at any time upon its own motion.

**SOURCES: Laws, 1991, ch. 417, § 16, eff from and after passage (approved March 20, 1991).**

## § 83-24-33. Petition for order directing liquidation; grounds.

The commissioner may petition the court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(a) Of any ground for an order of rehabilitation as specified in Section 83-24-23, whether or not there has been a prior order directing the rehabilitation of the insurer;

(b) That the insurer is insolvent; or

(c) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public.

**SOURCES: Laws, 1991, ch. 417, § 17, eff from and after passage (approved March 20, 1991).**

**Cross References** — Petition for order of liquidation, see § 83-24-31.

Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

## § 83-24-35. Commissioner, and his successors in office, as liquidator; rights, duties and responsibilities; terms of order to liquidate; financial reports; plan for continuation of insurer's business.

(1) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his successors in office as liquidator, and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County and of the county in which its principal office or place of business is located, or, in the case of real estate, of the county where the property is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(2) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in Sections 83-24-37 and 83-24-73.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(4) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's

insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

(5) Any order issued under this section shall require the liquidator to submit financial reports to the court. Financial reports shall include (at a minimum) the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one (1) year of the liquidation order and at least annually thereafter.

(6)(a) Within five (5) days of March 20, 1991, or, if later, within five (5) days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. If the defendant company's financial condition will not, in the judgment of the commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the commissioner and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the commissioner or any of his deputies, agents, clerks, assistants or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(b) The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

(c) Any such plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, and in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, if an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

**SOURCES: Laws, 1991, ch. 417, § 18, eff from and after passage (approved March 20, 1991).**

**Cross References —** Reciprocal state, defined, see § 83-24-7.

Report by liquidator after order of liquidation, see § 83-24-61.

Claims made under employment contracts by directors, principal officers, or persons performing similar functions, see § 83-24-73.

### RESEARCH REFERENCES

**Practice References.** Business Law Monographs, Volume IN2 — Casualty and Liability Insurance (Matthew Bender).

## § 83-24-37. Continuation of insurer's obligations; termination of coverages.

(1) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(a) A period of thirty (30) days from the date of entry of the liquidation orders;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation pursuant to Section 83-24-41; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order for liquidation under Section 83-24-39 shall terminate coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2).

**SOURCES: Laws, 1991, ch. 417, § 19, eff from and after passage (approved March 20, 1991).**

**Cross References —** Date of entry of order of liquidation as affecting rights of insurer, etc., see § 83-24-35.

## § 83-24-39. Petition for order to dissolve corporate existence.

The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

**SOURCES: Laws, 1991, ch. 417, § 20, eff from and after passage (approved March 20, 1991).**

**Cross References** — Continuation or termination of insurer's obligations, see § 83-24-37.

Powers and duties of liquidator, see § 83-24-41.

Maintenance of civil action for damages for benefit of insurer, if order for liquidation or rehabilitation of controlled insurer entered in accordance with this (Insurers Rehabilitation and Liquidation) Act, see § 83-59-11.

## § 83-24-41. Powers and duties of liquidator.

(1) The liquidator shall have the power:

(a) To appoint a special deputy or deputies to act for him under this chapter, and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator.

(b) To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation.

(c) To appoint, with the approval of the court, an advisory committee of policyholders, claimants or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in liquidation proceedings conducted under this chapter.

(d) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court.

(e) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available monies of the insurer.

(f) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry.

(g) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

(h) To collect all debts and monies due and claims belonging to the insurer, wherever located, and for this purpose:

(i) To institute timely action in other jurisdictions in order to forestall garnishment and attachment proceedings against such debts;

(ii) To do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as he deems best; and

(iii) To pursue any creditor's remedies available to enforce his claims.

(i) To conduct public and private sales of the property of the insurer.

(j) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 83-24-83.

(k) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(*l*) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution.

(m) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(n) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under Section 83-24-39, he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff.

(o) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person.

(p) To remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

(q) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions.

(r) To invest all sums not currently needed, unless the court orders otherwise.

(s) To file any necessary documents for record in the office of any chancery clerk or record office in this state or elsewhere where property of the insurer is located.

(t) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations.

(u) To exercise and enforce all the rights, remedies and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with Sections 83-24-51 through 83-24-55.

(v) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

(w) To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(x) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this chapter.

(2)(a) If a company placed in liquidation issued liability policies on a claims-made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims as stated herein. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen (18) months from the order of liquidation.

(b) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty (60) days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety (90) days after the order of liquidation. No commissions, premium taxes, assessments or other fees shall be due on the charge pertaining to the extended period to report claims.

(3) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(4) Notwithstanding the powers of the liquidator as stated in subsections (1) and (2) above, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

**SOURCES: Laws, 1991, ch. 417, § 21, eff from and after passage (approved March 20, 1991).**

**Cross References** — Continuation or termination of insurer's obligations, see § 83-24-37.

Priority of distribution of claims, see § 83-24-83.

## § 83-24-43. Notice of liquidation order; filing claims with liquidator.

(1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) By first class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

(b) By first class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) By first class mail to all insurance agents of the insurer;

(d) By first class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known address as indicated by the records of the insurer; and

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(2) Except as otherwise established by the liquidator with approval of the court, notice to potential claimants under subsection (1) shall require claimants to file with the liquidator their claims, together with proper proofs thereof under Section 83-24-71, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3)(a) Notice under subsection (1) to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(b) The liquidator shall promptly provide to the guaranty associations such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control, and otherwise cooperate with guaranty associations to assist them in providing to such policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(4) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

**SOURCES: Laws, 1991, ch. 417, § 22, eff from and after passage (approved March 20, 1991).**

**Cross References** — Filing proof of claims, see § 83-24-69.
Claim filed by insurer, see § 83-24-75.
Priority of distribution of claims, see § 83-24-83.

## § 83-24-45. Agent of insurer; duties following notice of liquidation; penalties.

(1) Every person who receives notice in the form prescribed in Section 83-24-43 that an insurer which he represents as an agent is the subject of a liquidation order shall, within thirty (30) days of such notice provide to the liquidator (in addition to the information he may be required to provide pursuant to Section 83-24-13) the information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to him, including the name and address of such subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(2) Any agent failing to provide information to the liquidator as required in subsection (1) may be subject to payment of a penalty of not more than One Thousand Dollars ($1,000.00) and may have his licenses suspended after a hearing held by the commissioner.

**SOURCES: Laws, 1991, ch. 417, § 23, eff from and after passage (approved March 20, 1991).**

## § 83-24-47. Action or proceeding against insurer after order appointing liquidator prohibited; injunctions; action on behalf of insurer; limitation of actions; rights of guaranty association.

(1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within two (2) years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition; the liquidator may, for the benefit of the estate, take any such action or do any such act required of or permitted to the insurer, within a period of one hundred eighty (180) days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the petition is denied.

(4) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

**SOURCES: Laws, 1991, ch. 417, § 24, eff from and after passage (approved March 20, 1991).**

## § 83-24-49. Preparation of list of insurer's assets.

(1) As soon as practicable after the liquidation order but not later than one hundred twenty (120) days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One (1) copy shall be filed in the office of the clerk of the chancery court and one (1) copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with Section 83-24-67 fulfills the requirements of subsection (1) of this section.

**SOURCES: Laws, 1991, ch. 417, § 25, eff from and after passage (approved March 20, 1991).**

## § 83-24-51. Transfers by insurer prior to petition for rehabilitation or liquidation; voiding transfers.

(1) Every transfer made or suffered and every obligation incurred by an insurer within one (1) year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be voided by the receiver, except as to a person who in good faith is a purchaser, lienor or obligee for a present fair equivalent value, and except that any purchaser, lienor or obligee, who in good faith has given a consideration less than fair for such transfer, lien or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event the receiver shall succeed to and may enforce the rights of the purchaser, lienor or obligee.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under Section 83-24-55.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be voided by the receiver under subsection (1) if:

(a) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(b) Any part of the transaction took place within one (1) year prior to the date of filing of the petition through which the receivership was commenced.

(4) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

**SOURCES: Laws, 1991, ch. 417, § 26, eff from and after passage (approved March 20, 1991).**

**Cross References** — Fraudulent transfers, voiding, see § 83-24-27.

Powers and duties of liquidator, see § 83-24-41.

Transfer of real property of insurer after petition for rehabilitation or liquidation, see § 83-24-53.

Preference transfer, see § 83-24-55.

Filing proof of claims, see § 83-24-69.

## § 83-24-53. Transfer of real property of insurer after petition for rehabilitation or liquidation.

(1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the chancery court in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(b) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(3) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

(4) Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

**SOURCES: Laws, 1991, ch. 417, § 27, eff from and after passage (approved March 20, 1991).**

**Cross References —** Fraudulent transfers, voiding, see § 83-24-27.
Powers and duties of liquidator, see § 83-24-41.
Transfers by insurer prior to petition for rehabilitation or liquidation, see § 83-24-51.

## § 83-24-55. Preference transfer; voiding.

(1)(a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one (1) year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one (1) year before the filing of the successful petition for rehabilitation, or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Any preference may be voided by the liquidator if:

(i) The insurer was insolvent at the time of the transfer; or

(ii) The transfer was made within four (4) months before the filing of the petition; or

(iii) The creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(iv) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding, directly or indirectly, more than five percent (5%) of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) When the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. If a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate and the lien or title shall pass to the liquidator.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3)(a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (2), if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (2) through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (2) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien deemed voidable under subsection (1)(b) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this chapter which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(6) The property affected by any lien deemed voidable under subsections (1) and (5) shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(7) The court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. When an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(8) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and voided by the liquidator, or where the property is retained under subsection (7) to the extent of the amount paid to the liquidator.

(9) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid

at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

(10) If an insurer shall, directly or indirectly, within four (4) months before the filing of a successful petition for liquidation under this chapter, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate. If the attorney is in a position of influence with the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of subsection (1)(b)(iv).

(11)(a) Every officer, manager, employee, shareholder, member, subscriber, attorney or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four (4) months before the date of filing of this successful petition for liquidation.

(b) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

(c) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

**SOURCES: Laws, 1991, ch. 417, § 28, eff from and after passage (approved March 20, 1991).**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (a) of subsection (1). The word "credit" was changed to "creditor ". The Joint Committee ratified the correction at its December 3, 1996, meeting.

**Cross References** — Powers and duties of liquidator, see § 83-24-41.

Transfer of property by insurer prior to petition for rehabilitation or liquidation, see § 83-24-51.

Filing proof of claims, see § 83-24-69.

## § 83-24-57. Surrender of preference, lien, conveyance, transfer, assignment or encumbrance by creditor.

(1) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this chapter shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a

proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty (30) days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance, may be filed as an excused last filing under Section 83-24-69 if filed within thirty (30) days from the date of the avoidance, or within the further time allowed by the court under subsection (1).

**SOURCES: Laws, 1991, ch. 417, § 29, eff from and after passage (approved March 20, 1991).**

**Cross References** — Filing proof of claims, see § 83-24-69.

## § 83-24-59. Mutual debts or mutual credits between insurer and another person; setoff.

(1) Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this chapter, shall be set off and the balance only shall be allowed or paid, except as provided in Section 83-24-65.

(2) No set off shall be allowed in favor of any person where:

(a) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer; or

(b) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a set off;

(c) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution.

**SOURCES: Laws, 1991, ch. 417, § 30; Laws, 1997, ch. 351, § 1, eff from and after July 1, 1997.**

## § 83-24-61. Report by liquidator after order of liquidation; assessments; notice.

(1) As soon as practicable but not more than two (2) years from the date of an order of liquidation under Section 83-24-35 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(a) The reasonable value of the assets of the insurer;

(b) The insurer's probable total liabilities;

(c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(d) A recommendation as to whether or not an assessment should be made and in what amount.

(2)(a) Upon the basis of the report provided in subsection (1), including any supplements and amendments thereto, the court may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2), the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(4) The liquidator shall give notice of the order to show cause by publication, and by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least twenty (20) days before the return day of the order, to show cause.

(5)(a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (3), the court shall make an order adjudging the member liable for the amount of the assessment against him pursuant to subsection (3), together with costs, and the liquidator shall have a judgment against the member therefor.

(b) If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) by any lawful means.

**SOURCES: Laws, 1991, ch. 417, § 31, eff from and after passage (approved March 20, 1991).**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 93, 94 et seq.

**CJS.** 44 C.J.S., Insurance § 193.

## § 83-24-63. Recovery from reinsurers; amount.

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

**SOURCES: Laws, 1991, ch. 417, § 32, eff from and after passage (approved March 20, 1991).**

## § 83-24-65. Payment of premiums; recovery of unearned premiums; credits; setoffs; violation of provisions; penalties; notice of violation; hearing; appeal.

(1)(a) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(b) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(2) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

(a) Suspend or revoke or refuse to renew the licenses of such offending party or parties.

(b) Impose a penalty of not more than One Thousand Dollars ($1,000.00) for each and every act in violation of this section by the party or parties.

(3) Before the commissioner shall take any action as set forth in subsection (2), he shall give written notice to the person, company, association or exchange accused of violating the law, stating specifically the nature of the alleged violation; and fixing a time and place, at least ten (10) days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing, the commissioner, if he shall find such violation, shall impose such of the penalties under subsection (2) as he deems advisable.

(4) When the commissioner shall take action in any or all of the ways set out in subsection (2), the party aggrieved may appeal the action to the court.

**SOURCES: Laws, 1991, ch. 417, § 33, eff from and after passage (approved March 20, 1991).**

**Cross References —** Setoff of mutual debts or mutual credits between insurer and another person, see § 83-24-59.

## § 83-24-67. Disbursement of assets after final determination of insolvency.

(1) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall apply to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in Classes 1 and 2 in Section 83-24-83;

(b) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in Section 83-24-83 in accordance with such priorities. No bond shall be required of any such association; and

(e) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming or guaranteeing policies or contracts of insurance under the acts creating such associations.

(5) Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be

deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Action on the application may be taken by the court, provided the above required notice has been given and provided further that the liquidator's proposal complies with subsections (2)(a) and (b).

**SOURCES: Laws, 1991, ch. 417, § 34, eff from and after passage (approved March 20, 1991).**

**Cross References** — Preparation of list of insurer's assets, see § 83-24-49.
Priority of distribution of claims, see § 83-24-83.

## § 83-24-69. Filing proof of claims; late filing.

(1) Proof of all claims shall be filed with the liquidator in the form required by Section 83-24-71 on or before the last day for filing specified in the notice required under Section 83-24-43, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(b) A transfer to a creditor was avoided under Sections 83-24-51 through 83-24-55, or was voluntarily surrendered under Section 83-24-57, and that the filing satisfies the conditions of Section 83-24-57;

(c) The valuation under Section 83-24-81, of security held by a secured creditor shows a deficiency, which is filed within thirty (30) days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(4) The liquidator may consider any claim filed late which is not covered by subsection (2), and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

**SOURCES: Laws, 1991, ch. 417, § 35, eff from and after passage (approved March 20, 1991).**

**Cross References —** Surrender of preference, lien, conveyance, transfer, assignment or encumbrance by creditor, see § 83-24-57.

Content of proof of claims, see § 83-24-71.

Contingent claims, see § 83-24-73.

Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

## § 83-24-71. Content of proof of claims.

(1) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(a) The particulars of the claim including the consideration given for it;

(b) The identity and amount of the security on the claim;

(c) The payments made on the debt, if any;

(d) That the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(e) Any right of priority of payment or other specific right asserted by the claimants;

(f) A copy of the written instrument which is the foundation of the claim; and

(g) The name and address of the claimant and the attorney who represents him, if any.

(2) No claim need be considered or allowed if it does not contain all the information in subsection (1) which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(3) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion, need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four (4) months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

**SOURCES: Laws, 1991, ch. 417, § 36, eff from and after passage (approved March 20, 1991).**

**Cross References —** Notice of liquidation order, see § 83-24-43.

Filing proof of claims, see § 83-24-69.

Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

## § 83-24-73. Claim of third party which is contingent on obtaining judgment against insurer; claims due except for passage of time; employment contracts.

(1) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(2) A claim may be allowed even if contingent, if it is filed in accordance with Section 83-24-69. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under Section 83-24-25 or Section 83-24-35.

**SOURCES: Laws, 1991, ch. 417, § 37, eff from and after passage (approved March 20, 1991).**

**Cross References** — Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

## § 83-24-75. Third party claim filed with liquidator; insured filing claim; claim subject to coverage by guaranty association.

(1) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty (60) days after mailing of the notice required by Section 83-24-43, whichever is later, he is an unexcused late filer.

(3) The liquidator shall make his recommendations to the court under Section 83-24-83, for the allowance of an insured's claim under subsection (2) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its

allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of (a) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or (b) the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one (1) policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (3). If any insured's claim is subsequently reduced under subsection (3), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(5) No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

**SOURCES: Laws, 1991, ch. 417, § 38, eff from and after passage (approved March 20, 1991).**

## § 83-24-77. Denial of claim; notice; objection to denial; hearing.

(1) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first class mail at the address shown in the proof of claim. Within sixty (60) days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected not less than ten (10) nor more than thirty (30) days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

**SOURCES: Laws, 1991, ch. 417, § 39, eff from and after passage (approved March 20, 1991).**

**Cross References** — Resolving disputes as to claims, see § 83-24-85.

Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

## § 83-24-79. Failure of secured creditor to file claim; distribution on claim.

Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution; however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person," as used in this section is not intended to apply to a guaranty association or foreign guaranty association.

**SOURCES: Laws, 1991, ch. 417, § 40, eff from and after passage (approved March 20, 1991).**

**Cross References** — Filing proof of claims, see § 83-24-69.

## § 83-24-81. Value of security held by secured creditor; determination.

(1) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(b) By agreement, arbitration, compromise or litigation between the creditor and the liquidator.

(2) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

**SOURCES: Laws, 1991, ch. 417, § 41, eff from and after passage (approved March 20, 1991).**

**Cross References** — Filing proof of claims, see § 83-24-69.

Liquidation proceeding in Mississippi involving one or more reciprocal states, see § 83-24-115.

## § 83-24-83. Priority of distribution of claims; order of distribution.

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth.

Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) **Class 1.** — The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer;

(b) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation;

(f) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

(2) **Class 2.** — All claims under policies including such claims of the federal or any state or local government for losses incurred ("loss claims") including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

(3) **Class 3.** — Claims under nonassessable policies for unearned premium or other premium refunds.

(4) **Class 4.** — Claims of the federal government not included in Class 2 or 3 above.

(5) **Class 5.** — Reasonable compensation to employees for services performed to the extent that they do not exceed two (2) months of monetary compensation and represent payment for services performed within one (1) year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one (1) year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(6) **Class 6.** — Claims of general creditors including claims of ceding and assuming companies in their capacity as such.

(7) **Class 7.** — Claims of any state or local government except those under Class 2 or 3 above. Claims, including those of any state or local governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction,

or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (10).

(8) **Class 8.** — Claims filed late or any other claims other than claims under subsections (9) and (10).

(9) **Class 9.** — Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(10) **Class 10.** — The claims of shareholders or other owners in their capacity as shareholders.

**SOURCES: Laws, 1991, ch. 417, § 42; Laws, 2000, ch. 431, § 1, eff from and after passage (approved Apr. 18, 2000.)**

**Editor's Note —** Laws of 2000, ch. 431, § 2, provides:

"SECTION 2. It is the intent of the Legislature that Section 83-24-83 as amended by this act applies to pending and future claims in existing delinquency proceedings as well as to claims in delinquency proceedings arising after the effective date of this act; that, in light of the ruling of the United States Supreme Court in U.S. Department of the Treasury v. Fabe, 113 S.Ct. 2202 (1993), the Legislature considers this act to be curative, remedial and not affecting substantive rights in the distribution of assets in delinquency proceedings; that this act is necessary to cure any potential defect in the present priority of distribution scheme that may result from the Fabe decision and to preserve the original intent of the Legislature with regard to the priorities of payment in delinquency proceedings."

Laws of 2000, ch. 431, § 3, provides:

"SECTION 3. If any classification or priority provided for in Section 1 of this act is held to be unconstitutional or otherwise invalid, the remaining classifications and priorities shall continue in effect."

**Cross References —** Powers and duties of liquidator, see § 83-24-41.

Disbursement of assets after final determination of insolvency, see § 83-24-67.

Filing proof of claims, see § 83-24-69.

Content of proof of claims, see § 83-24-71.

Claim filed by insurer, see § 83-24-75.

Payment of distributions, see § 83-24-87.

Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

Claims belonging to claimants residing in reciprocal states, see § 83-24-109.

## § 83-24-85. Review of claims filed in liquidation; reports; power and duty of court.

(1) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise or in any other manner negotiate the amount for which claims will be recommended to the court except when the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under Section 83-24-77. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each

claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty (60) days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to Section 83-24-77. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

**SOURCES: Laws, 1991, ch. 417, § 43, eff from and after passage (approved March 20, 1991).**

**Cross References** — Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

## § 83-24-87. Payment of distributions.

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

**SOURCES: Laws, 1991, ch. 417, § 44, eff from and after passage (approved March 20, 1991).**

**Cross References** — Priority of distribution of claims, see § 83-24-83.

## § 83-24-89. Deposit of unpaid funds with State Treasurer; escheat proceedings.

(1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the State Treasurer, and shall be paid without interest except in accordance with Section 83-24-83 to the person entitled thereto or his legal representative upon proof satisfactory to the State Treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and shall be deposited into the General Fund.

(2) All funds withheld under Section 83-24-73 and not distributed shall upon discharge of the liquidator be deposited with the State Treasurer and paid by him in accordance with Section 83-24-83. Any sums remaining which

under Section 83-24-83 would revert to the undistributed assets of the insurer shall be transferred to the State Treasurer and become the property of the state under subsection (1), unless the commissioner, in his discretion, petitions the court to reopen the liquidation under Section 83-24-93.

**SOURCES: Laws, 1991, ch. 417, § 45, eff from and after passage (approved March 20, 1991).**

## § 83-24-91. Application for order of discharge; costs and expenses.

(1) When all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

**SOURCES: Laws, 1991, ch. 417, § 46, eff from and after passage (approved March 20, 1991).**

## § 83-24-93. Reopening proceedings after discharge of liquidator; orders.

After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

**SOURCES: Laws, 1991, ch. 417, § 47, eff from and after passage (approved March 20, 1991).**

**Cross References** — Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

## § 83-24-95. Destruction of records.

Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

**SOURCES: Laws, 1991, ch. 417, § 48, eff from and after passage (approved March 20, 1991).**

## § 83-24-97. Audit of books of commissioner relating to receivership established under this chapter; reports; expenses.

The court may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this chapter, and a report of each audit shall be filed with the commissioner and with the court. The books, records and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

**SOURCES: Laws, 1991, ch. 417, § 49, eff from and after passage (approved March 20, 1991).**

## § 83-24-99. Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator; orders.

(1) If a domiciliary liquidator has not been appointed, the commissioner may apply to the court by verified petition for an order directing him to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) Any of the grounds in Section 83-24-23;

(b) That any of the insurer's property has been sequestered by official action in its domiciliary state, or in any other state;

(c) That enough of the insurer's property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(d)(i) That the insurer's certificate of authority to do business in this state has been revoked or that none was ever issued; and

(ii) That there are residents of this state with outstanding claims or outstanding policies.

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is located shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under Section 83-24-101 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under Section 83-24-105 to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such

finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

**SOURCES: Laws, 1991, ch. 417, § 50, eff from and after passage (approved March 20, 1991).**

**Cross References** — Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

Vesting title to assets in liquidator, see § 83-24-103.

### RESEARCH REFERENCES

**ALR.** Dissolving or winding up affairs of corporation domiciled in another state. 19 A.L.R.3d 1279.

**Am Jur.** 36 Am. Jur. 2d, Foreign Corporations §§ 413 et seq.

**CJS.** 20 C.J.S., Foreign Corporations §§ 1898 et seq.

## § 83-24-101. Application by commissioner for order permitting liquidation of assets found in state of foreign insurer or alien insurer not domiciled in state; notice; filing or recording order; domiciliary liquidator appointed in reciprocal state or nonreciprocal state; payment of claims.

(1) If no domiciliary receiver has been appointed, the commissioner may apply to the court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(i) Any of the grounds in Section 83-24-23 or 83-24-33; or

(ii) Any of the grounds specified in Section 83-24-99(1)(b) through (d).

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under Section 83-24-105. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under Section 83-24-105.

(5) On the same grounds as are specified in subsection (1), the commissioner may petition any appropriate federal district court to be appointed

receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the commissioner, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this chapter as are otherwise compatible with the provisions of this section.

**SOURCES: Laws, 1991, ch. 417, § 51, eff from and after passage (approved March 20, 1991).**

**Cross References** — Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Vesting title to assets in liquidator, see § 83-24-103.

## § 83-24-103. Vesting of title to assets in liquidator; filing claim with liquidator or ancillary receiver.

(1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under Section 83-24-105(3), be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to Section 83-24-105.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under Section 83-24-99 or 83-24-101, or for an ancillary receivership under Section 83-24-105 or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

**SOURCES: Laws, 1991, ch. 417, § 52, eff from and after passage (approved March 20, 1991).**

**Cross References** — Reciprocal state, defined, see § 83-24-7.

## § 83-24-105. Petition for appointment as ancillary receiver; orders.

(1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the court requesting appointment as ancillary receiver in this state:

(a) If he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver;

(b) If the protection of creditors or policyholders in this state so requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the chancery court in this state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (3) for ancillary receivers appointed in this state.

**SOURCES: Laws, 1991, ch. 417, § 53, eff from and after passage (approved March 20, 1991).**

**Cross References** — Reciprocal state, defined, see § 83-24-7.

Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

Vesting title to assets in liquidator, see § 83-24-103.

### § 83-24-107. Discretion of commissioner of insurance to institute proceedings.

The commissioner in his sole discretion may institute proceedings under Sections 83-24-19 and 83-24-21 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

**SOURCES: Laws, 1991, ch. 417, § 54, eff from and after passage (approved March 20, 1991).**

### § 83-24-109. Claimants residing in foreign country or in states not reciprocal states; time requirements; notice; claims by claimants residing in reciprocal states.

(1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this chapter, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in Section 83-24-111(2) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under Section 83-24-83.

**SOURCES: Laws, 1991, ch. 417, § 55, eff from and after passage (approved March 20, 1991).**

**Cross References** — Reciprocal state, defined, see § 83-24-7.
Filing proof of claims, see § 83-24-69.
Contents of proof of claims, see § 83-24-71.

### § 83-24-111. Liquidation proceeding in reciprocal state against insurer domiciled in that state; claims by residents of Mississippi; notice; hearings; final allowance.

(1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or

with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in Sections 83-24-69 and 83-24-71. The ancillary receiver shall make his recommendation to the court as under Section 83-24-85. He shall also arrange a date for hearing if necessary under Section 83-24-77 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty (40) days prior to the date set for hearing. If the domiciliary liquidator, within thirty (30) days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

**SOURCES: Laws, 1991, ch. 417, § 56, eff from and after passage (approved March 20, 1991).**

**Cross References** — Reciprocal state, defined, see § 83-24-7.
Filing proof of claims, see § 83-24-69.
Contents of proof of claims, see § 83-24-71.
Claims belonging to claimants residing in reciprocal states, see § 83-24-109.

## § 83-24-113. Attachment, garnishment or levy of execution against delinquent insurer during pendency of liquidation proceedings.

During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

**SOURCES: Laws, 1991, ch. 417, § 57, eff from and after passage (approved March 20, 1991).**

**Cross References** — Reciprocal state, defined, see § 83-24-7.

## § 83-24-115. Liquidation proceeding in Mississippi involving one or more reciprocal states; order of distribution; priority of claims; special deposit claims; surrender of secured claim.

(1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control

as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secure claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with Section 83-24-81, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

**SOURCES: Laws, 1991, ch. 417, § 58, eff from and after passage (approved March 20, 1991).**

**Cross References —** Priority of distribution of claims, see § 83-24-83.

## § 83-24-117. Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator.

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under Section 83-24-83(7).

**SOURCES: Laws, 1991, ch. 417, § 59, eff from and after passage (approved March 20, 1991).**

**Cross References —** Priority of distribution of claims, see § 83-24-83.

Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator, see § 83-24-117.

# CHAPTER 25

## Co-operative Insurance

Sec.
83-25-1. Charter, bylaws, rules, to be filed with commissioner.
83-25-3. Policies to agree with charter and bylaws.
83-25-5. Report and publication.

### § 83-25-1. Charter, bylaws, rules, to be filed with commissioner.

Every corporation, company, society, organization, or association of this or of any other state or country transacting the business of life insurance upon the co-operative or assessment plan shall file with the commissioner of insurance, before commencing to do business in this state, a copy of its charter or articles of association, as well as the bylaws, rules, or regulations referred to in its policies or certificates and made a part of said contract. No bylaws or regulations, unless so filed with the commissioner, shall operate to avoid or affect any policy or certificate issued by such company or association.

**SOURCES: Codes, 1906, § 2636; Hemingway's 1917, § 5102; 1930, § 5180; 1942, § 5690.**

#### RESEARCH REFERENCES

**CJS.** 44 C.J.S., Insurance §§ 579 et seq.

### § 83-25-3. Policies to agree with charter and bylaws.

Every policy or certificate or renewal receipt issued to a resident of the State of Mississippi by any corporation, association, or order therein transacting the business of life insurance upon the assessment plan shall be in accord with the provisions of the charter and bylaws of said corporation, association, or order, as filed with the commissioner of insurance. It shall be unlawful for any domestic or foreign insurance company or fraternal order to transact or offer to transact any business not authorized by the provisions of their charter and the terms of their bylaws, or through an agent, or otherwise to offer or issue any policy, renewal, certificate, or other contract, the terms of which are not in clear accord with the powers, terms, and stipulations of their charters and bylaws. Upon a proper application by any citizen of this state, it shall be the duty of the commissioner to give a statement or synopsis of the provisions of any insurance contract offered or issued to such citizen. If any such corporation or association or order shall at any time fail or refuse to comply with the provisions of this section, the commissioner shall forthwith suspend or revoke all authority to such corporation, association, or order, and all its agents or officers to do business in this state, and shall publish such revocation in some newspaper published in this state.

**SOURCES: Codes, 1906, § 2635; Hemingway's 1917, § 5101; 1930, § 5179; 1942, § 5689.**

**Cross References** — Requirement of certain words and language in every life insurance policy, see § 83-7-17.

Personal liability of insurance agent, see § 83-17-3.

Benefits payable by fraternal societies, see § 83-29-9.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 67, 68.

**CJS.** 44 C.J.S., Insurance §§ 91, 92.

## § 83-25-5. Report and publication.

Every corporation, company, society, organization, or association of this or any other state or country transacting the business of life insurance on the co-operative or assessment plan shall, on or before the first day of March of each year, make and file with the commissioner of insurance a report of its affairs and operations during the year ending on the 31st day of December immediately preceding. Such report shall be upon blank forms to be provided by the commissioner; and shall be verified under oath by the duly authorized officers of such corporation, society, order, or association; shall be published, or the substance thereof, in some newspaper published in the state at the expense of said company, corporation, order, etc., and in his annual report by the commissioner under a separate part, entitled "Assessment Companies or Associations"; and shall contain such information as the commissioner in his judgment may deem necessary for the welfare of the people of the state, subject to like penalties imposed in Section 83-5-69.

**SOURCES: Codes, 1906, § 2634; Hemingway's 1917, § 5100; 1930, § 5178; 1942, § 5688.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance § 96.

# CHAPTER 27

## Surety Companies

SEC.
83-27-1. Accepted as sureties on bonds.
83-27-3. Must show compliance with law.
83-27-5. Capital of $100,000 in securities required.
83-27-7. Agents.
83-27-9. Liability limited to one tenth of capital and surplus.
83-27-11. Estopped to deny corporate powers.

### § 83-27-1. Accepted as sureties on bonds.

Any company incorporated and organized under the laws of any state of the United States for the purpose of transacting business as surety on obligations of persons or corporations, which has complied with all the requirements of this chapter may be accepted as surety in part, or as sole surety, upon the bond of any person, officer or corporation required by the laws of this state to execute a bond or bonds. Such company may be substituted as sole surety or as co-surety for a surety or sureties on bonds already given, and may be released from liability on the same terms and conditions as are by law prescribed for the substitution and release of individuals as sureties. Where a surety company subscribes to a bond, it shall not be necessary that there shall be additional sureties. In all cases where such company shall become surety for part only of any bond, its liability on such bond shall be limited to the amount for which it becomes surety. All surety companies shall possess the capital and surplus requirements as required in Sections 83-19-31 and 83-21-3.

**SOURCES: Codes, 1906, § 2669; Hemingway's 1917, § 5135; 1930, § 5225; 1942, § 5739; Laws, 1896, ch. 55; Laws, 1997, ch. 410, § 18, eff from and after July 1, 1997.**

**Cross References —** Constitutional authority for acceptance of surety company on official bond, see MS Const Art. 4, § 82.

Statutory requirement of surety bonds for state officials, see § 25-1-13.

Procedure for release from official bond, see § 25-1-29.

Surety bonds for employees of common carriers, see §§ 77-9-27 et seq.

Action by surety company against defaulting principal, see §§ 87-5-5 et seq.

#### RESEARCH REFERENCES

**ALR.** Fidelity bond termination clause on taking over of insured by another business entity: construction and effect. 44 A.L.R.4th 1195.

**Am Jur.** 74 Am. Jur. 2d, Suretyship § 202.

**CJS.** 44 C.J.S., Insurance §§ 76-80.

### § 83-27-3. Must show compliance with law.

Before such company shall be accepted as surety, it shall produce to the judge, head of department, or other officer authorized to approve such bond satisfactory evidence of its compliance with and fulfillment of all the requirements of this chapter.

**SOURCES: Codes, 1906, § 2670; Hemingway's 1917, § 5136; 1930, § 5226; 1942, § 5740; Laws, 1894, ch. 64.**

**RESEARCH REFERENCES**

**Am Jur.** 74 Am. Jur. 2d, Suretyship § 202.

**CJS.** 44 C.J.S., Insurance §§ 76-80.

## § 83-27-5. Capital of $100,000 in securities required.

No such company shall be accepted as surety unless the amount of at least One Hundred Thousand Dollars ($100,000.00) of its said paid-up capital is invested in solvent securities created by the laws of the United States or of the State of Mississippi or by or under the laws of the state by which such company is incorporated, or in other safe securities the value of which, at the time of such acceptance, shall be at or above par and which are deposited with the insurance commissioner, auditor, comptroller, or chief financial officer of the state under whose laws such company is incorporated, and the commissioner of insurance of this state is furnished with the certificate of such commissioner, auditor, comptroller, or officer, under his hand and official seal that he, as said insurance commissioner, auditor, comptroller, or chief financial officer of said state holds the said securities in trust and on deposit for the benefit of such obligees of such company, which certificate shall describe the items of security so held and shall state that he is satisfied they are worth One Hundred Thousand Dollars ($100,000.00).

**SOURCES: Codes, 1906, § 2671; Hemingway's 1917, § 5137; 1930, § 5227; 1942, § 5741.**

**Cross References** — Limitation of liability, see § 83-27-9.

**RESEARCH REFERENCES**

**Am Jur.** 43 Am. Jur. 2d, Insurance § 72.

**CJS.** 44 C.J.S., Insurance §§ 121-123.

## § 83-27-7. Agents.

Every person who shall so represent any such company as to receive or transmit applications for suretyship, or to receive for delivery bonds founded on applications from this state, or otherwise to procure suretyship to be effected by said company upon the bonds of persons or corporations in this state, or upon bonds given to persons or corporations in this state, shall be deemed as an agent for such company. No person shall act as agent for such company until such company shall have complied with all of the requirements of this chapter, under penalty of a fine of One Thousand Dollars ($1,000.00).

**SOURCES: Codes, 1906, § 2672; Hemingway's 1917, § 5138; 1930, § 5228; 1942, § 5742.**

**Cross References** — Definition of insurance agent generally, see § 83-17-1.

### JUDICIAL DECISIONS

**1. In general.**

Where agent of surety company delivered appeal bond as company's bond, company was estopped from denying agent's authority or that signature was not binding on them. Champenois & Blanks v. Donald Co., 153 Miss. 719, 121 So. 485 (1929).

### RESEARCH REFERENCES

**Am Jur.** 74 Am. Jur. 2d, Suretyship § 203.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-27-9. Liability limited to one tenth of capital and surplus.

No company shall be accepted as surety on any bond for an amount larger than one tenth (1/10) of the company's paid-up capital and surplus as reflected in its last annual statement, unless it shall be secured from loss beyond such amount by reinsurance in an authorized company or by the amount of any cosuretyship, provided such reinsurance or cosurety shall not exceed the limits set forth herein for the prime surety, or by the value of any security deposited, pledged, or held subject to the company's consent and for its protection.

**SOURCES: Codes, 1906, § 2673; Hemingway's 1917, § 5139; 1930, § 5229; 1942, § 5743; Laws, 1970, ch. 453, § 1, eff from and after passage (approved March 24, 1970).**

**Cross References** — Required deposit of securities, see § 83-27-5.

### RESEARCH REFERENCES

**Am Jur.** 44A Am. Jur. 2d, Insurance §§ 1842 et seq.

**CJS.** 46 C.J.S., Insurance §§ 1720 et seq.

## § 83-27-11. Estopped to deny corporate powers.

Any company who shall execute any bond as surety shall, in any proceeding to enforce the liability which it shall have assumed to incur, be estopped to deny its corporate power to execute such instrument or assume such liability. Nor shall any failure to comply with any or all of the provisions of this chapter avail said company as a defense in any such proceedings.

**SOURCES: Codes, 1906, § 2674; Hemingway's 1917, § 5140; 1930, § 5230; 1942, § 5744.**

## RESEARCH REFERENCES

**Am Jur.** 44 Am. Jur. 2d, Insurance § 1058, 1060, 1061.

**CJS.** 45 C.J.S., Insurance § 1012-1014.

# CHAPTER 29

## Fraternal Societies

Sec.
83-29-1. Fraternal benefit societies defined.
83-29-3. Lodge system defined.
83-29-5. Representative form of government defined.
83-29-7. Exemptions.
83-29-9. Benefits.
83-29-11. Members and beneficiaries.
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83-29-69. Authority of fraternal orders revoked for failure to pay judgments.
83-29-71. Conversion of fraternal benefit societies into stock companies.
83-29-73. Fraternal societies may insure children.
83-29-75. Conditions under which certificates to be issued.

### § 83-29-1. Fraternal benefit societies defined.

Any corporation, society, order, or voluntary association without capital stock, organized and carried on solely for the mutual benefit of its members and their beneficiaries and not for profit, and having less than Thirty Thousand Dollars ($30,000.00) in total annual written premium, having a lodge system and representative form of government, or which limits its membership to a secret fraternity having a lodge system and representative form of government, and which shall make provision for the payment of benefits in accordance with Section 83-29-9 is hereby declared to be a fraternal benefit society.

**SOURCES: Codes, 1930, § 5231; 1942, § 5745; Laws, 2001, ch. 362, § 42, eff from and after July 1, 2001.**

**Cross References —** Administrative supervision of insurers by Commissioner of Insurance, see §§ 83-1-151 et seq.

Exclusion of fraternal benefit society from requirement of minimum surplus, see § 83-19-77.

Larger fraternal benefit societies defined, see §§ 83-30-1 et seq.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 1 et seq. (actions to recover on benefit certificates or policies; in general).

**CJS.** 10 C.J.S., Beneficial Associations § 1.

## § 83-29-3. Lodge system defined.

Any society having a supreme governing or legislative body and subordinate lodges or branches by whatever name known, into which members shall be admitted in accordance with its constitution, laws, ritual, rules, and regulations, and which shall be required by the laws of such society to hold periodical meetings, shall be deemed to be operating on the lodge system.

**SOURCES: Codes, 1930, § 5232; 1942, § 5746.**

**Cross References —** Definition of lodge system as it applies to larger fraternal benefit societies, see § 83-30-3.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 71 et seq. (suspension or expulsion of subordinate lodges).

**CJS.** 10 C.J.S., Beneficial Associations § 4.

## § 83-29-5. Representative form of government defined.

Any society shall be deemed to have a representative form of government when it shall provide in its constitution and laws for a supreme legislative or governing body, composed of representatives elected either by the members or by delegates elected directly or indirectly by the members, together with such other members as may be prescribed by its constitution and laws. The elective members shall constitute a majority in number and not less than the number of votes required to amend its constitution and laws; and the meetings of the supreme or governing body, and the election of officers, representatives, or delegates shall be held as often as once in four (4) calendar years. No member under age sixteen (16) shall have a voice or vote in the management of the society. No member, officer, representative, or delegate shall vote by proxy.

**SOURCES: Codes, 1930, § 5233; 1942, § 5747.**

**Cross References** — Definition of representative form of government as it applies to larger fraternal benefit societies, see § 83-30-5.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

**CJS.** 10 C.J.S., Beneficial Associations § 60.

## § 83-29-7. Exemptions.

Except as herein provided, such societies shall be governed by this chapter and shall be exempt from all provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. No law hereafter enacted shall apply to them unless they be expressly designated therein.

**SOURCES: Codes, 1930, § 5234; 1942, § 5748.**

**Cross References** — Laws applicable to domestic insurance companies, see § 83-5-13.

Exclusion of larger fraternal benefit societies from insurance laws of state, see § 83-30-45.

Exclusion of fraternal societies from laws governing burial associations, see § 83-37-33.

### JUDICIAL DECISIONS

**1. In general.**

A conversion of a fraternal society into a mutual life and disability company destroyed the immunity provided by this section [Code 1942, § 5748]; and consequently, a mutual company, so converted, was bound by the acts of its agents in misleading an insured as to the extent of disability necessary to entitle him to file a claim therefor, the act of the agent in that regard being the act of the company itself, under Code 1930, § 5196 [Code 1942, § 5706]. Columbian Mut. Life Ins. Co. v. Gipson, 185 Miss. 890, 189 So. 799 (1939).

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 4-7.

**CJS.** 10 C.J.S., Beneficial Associations § 2.

## § 83-29-9. Benefits.

(1) Every society transacting business under this chapter may provide for the payments of benefits upon the death of its members either within a term of years or at any time, may provide for benefits payable upon its members reaching seventy (70) years of age, may also provide for the payment of benefits

in case of total and permanent disability, may provide also for the payment of benefits in the event of temporary disability, and may provide for monuments or tombstones to the memory of its deceased members and for the payment of funeral benefits.

(2) Any society may also enter into contracts in such other forms and granting such benefits as its laws may authorize when it shall provide for the accumulation and maintenance of assets required for the payment of such benefits when valued upon an interest basis not exceeding four percent (4%) per annum and mortality standards adopted by it within the limitations provided in the statutes relating to fraternal benefit societies or, at the option of the society, in the statutes relating to life insurance companies.

**SOURCES: Codes, 1930, § 5235; 1942, § 5749; Laws, 1966, ch. 533, § 1, eff from and after passage (approved June 11, 1966).**

**Cross References —** Life insurance generally, see §§ 83-7-1 et seq.

Requirement that contracts for benefits be authorized by charter and bylaws, see § 83-25-3.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 82 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 1 et seq. (actions to recover on benefit certificates or policies; in general).

**CJS.** 10 C.J.S., Beneficial Associations §§ 34, 35.

## § 83-29-11. Members and beneficiaries.

Any person may be admitted to beneficial, or general, or social membership in any society in such manner and upon such showing of eligibility as the laws of the society may provide, and any beneficial member may direct any benefit to be paid to such person or persons, entity, or interest as may be permitted by the laws of the society. No beneficiary shall have or obtain any vested interest in the said benefit until the same has become due and payable in conformity with the provisions of the contract of membership, and the member shall have full right to change his beneficiary, or beneficiaries, in accordance with the laws, rules, and regulations of the society.

**SOURCES: Codes, 1930, § 5236; 1942, § 5750.**

### JUDICIAL DECISIONS

**1. In general.**

Insured, as member of fraternal order, was subject to the constitution and bylaws thereof, and beneficiary could not recover for disability resulting from insured's insanity where payment of dues and installments were not continued and the notice of disability was not given the order as required by the constitution and the policy. Columbian Mut. Life Ins. Co. v. Eaves, 185 Miss. 127, 185 So. 557 (1939).

### RESEARCH REFERENCES

**ALR.** Rights and liabilities arising out of contract for lifetime membership in social or fraternal club or association. 10 A.L.R.3d 1357.

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 49 et seq., 129 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 21 et seq. (membership); 31 et seq. (beneficiaries).

**CJS.** 10 C.J.S., Beneficial Associations §§ 41 et seq.

## § 83-29-13. Certificate.

The certificate, the charter or articles of incorporation or, if a voluntary association, the articles of association, constitution and laws of the society, and the application for membership signed by the applicant, and all amendments to each thereof shall constitute the agreement between the society and the member; and copies of the same certified by the secretary of the society, or corresponding officer, shall be received in evidence of the terms and conditions thereof. Any changes, additions, or amendments to said charter or articles of incorporation, or articles of association, if a voluntary association, constitution or laws duly made or enacted subsequent to the issuance of the benefit certificate shall bind the member and his beneficiaries, and shall govern and control the agreement in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for membership.

**SOURCES: Codes, 1930, § 5237; 1942, § 5751.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 10-12, 80 et seq.

**CJS.** 10 C.J.S., Beneficial Associations §§ 7-10, 34.

## § 83-29-15. Funds.

(1) Any society may create, maintain, invest, disburse, and apply an emergency, surplus, or other fund consistent with the purposes for which such society is organized, including hospital and health, home, thrift, pension for its employees, patriotic, educational, and relief funds, in accordance with its laws. Unless otherwise provided in the contract, such funds shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment or the surrender of any part thereof, except as provided in subsection (2) of Section 83-29-9. The funds from which benefits shall be paid and the funds from which the expenses of the society shall be defrayed shall be derived from periodical or other payments by the members of the society and accretions of said funds. All societies hereafter incorporated or foreign societies hereafter admitted shall be one hundred percent (100%) solvent according to the valuation requirements of Section 83-29-43.

(2) Deferred payments of installments of claims shall be considered as fixed liabilities on the happening of the contingency upon which such payments or installments are thereafter to be paid. Such liability shall be the present value of such future payments or installments upon the rate of interest and mortality assumed by the society for valuations, and every society shall maintain a fund sufficient to meet such liability regardless of proposed future collections to meet any such liabilities.

**SOURCES: Codes, 1930, § 5238; 1942, § 5752.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

**CJS.** 10 C.J.S., Beneficial Associations § 32.

## § 83-29-17. Investments.

Every society shall invest its funds only in securities permitted by the laws of this state for the investment of the assets of life insurance companies, and such securities shall be valued according to the methods used in valuing similar securities held by life insurance companies. Any foreign society permitted or seeking to do business in this state, which invests its funds in accordance with the laws of the state in which it is incorporated, shall be held to meet the requirements of this chapter for the investment of funds.

**SOURCES: Codes, 1930, § 5239; 1942, § 5753.**

**Cross References** — Approved investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

Approved investments for assets of larger fraternal benefit societies, see § 83-30-41.

Approved investments for assets of mutual companies, see § 83-31-29.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 22.

**CJS.** 10 C.J.S., Beneficial Associations § 30.

## § 83-29-19. Distribution of funds.

(1) Every society which is one hundred percent (100%) solvent according to the requirements of Section 83-29-43 in respect of the whole society, or of a class or section thereof, shall collect sufficient periodical or other contributions from the members of the society, or of such class or section thereof, which, with interest accretions, are sufficient to pay the claims arising from the certificates of the whole society, or of such class or section thereof, and its expenses, and to maintain a fund sufficient to meet its accrued liabilities and the reserves required to maintain the said percentage of solvency in accordance with the said Section 83-29-43 or, in lieu thereof, shall comply with subsection (2) of this section.

(2) Every other society, or other class or section thereof, shall collect from the members of such society, or other class or section thereof, stated periodical or other contributions expressly collected for the mortuary or disability funds, and periodical or other contributions expressly collected for the expense or management fund, both of which may be included in the periodical contribution. No part of the money collected for the mortuary or disability funds, or of the funds, or of the interest accretions thereto shall be used for expense purposes.

**SOURCES: Codes, 1930, § 5240; 1942, § 5754.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

**CJS.** 10 C.J.S., Beneficial Associations § 32.

## § 83-29-21. Organization.

Seven (7) or more persons, citizens of the United States and a majority of whom are citizens of this state, who desire to form a fraternal benefit society, as defined by this chapter, may make, sign, giving their addresses, and acknowledge, before some officer competent to take acknowledgment of deeds, article of incorporation in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company already transacting business in this state as to mislead the public or to lead to confusion;

(b) The purpose for which it is formed — which shall not include more liberal powers than are granted by this chapter, provided that any lawful social, intellectual, educational, charitable, benevolent, moral, or religious advantages may be set forth among the purposes of the society — and the mode in which its corporate powers are to be exercised;

(c) The names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control and management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme legislative or governing body, which election shall be held not later than one (1) year from the date of the issuance of the permanent certificate.

Such articles of incorporation, duly certified copies of the constitution and laws, rules and regulations, copies of all proposed forms of benefit certificates, applications therefor, circulars to be issued by such society, and a bond in the sum of Five Thousand Dollars ($5,000.00), with sureties approved by the commissioner of insurance, conditioned upon the return, as provided in this section, of the advance payments to applicants if the organization is not completed within one (1) year, shall be filed with the commissioner of insurance, who may require such further information as he deems necessary. If the purposes of the society conform to the requirements of this chapter and all provisions of law have been complied with, the commissioner of insurance shall so certify and retain and record, or file, the articles of incorporation, and furnish the incorporators a preliminary certificate authorizing said society to solicit members as hereinafter provided.

Upon receipt of said certificate from the commissioner of insurance, said society may solicit members for the purpose of completing its organization and shall collect from each applicant the amount of not less than one (1) regular monthly payment, in accordance with its table of rates as provided by its constitution and laws, and shall issue to each such applicant a receipt for the amount so collected. No such society shall incur any liability other than for such advanced payments, nor issue any benefit certificate, nor pay or allow, or offer or promise to pay or allow, to any person any death or disability benefit until actual bona fide applications for death benefit certificates have been secured upon at least five hundred (500) lives for at least One Thousand Dollars ($1,000.00) each, and all such applicants for death benefits shall have been regularly examined by legally qualified practicing physicians, and certificates of such examinations have been duly filed and approved by the chief medical examiner of such society; nor until there shall be established ten subordinate lodges or branches into which said five hundred (500) applicants have been initiated; nor until there has been submitted to the commissioner of insurance, under oath of the president and secretary or corresponding officers of such society, a list of such applicants, giving their names, addresses, date examined, date approved, date initiated, name and number of the subordinate branch of which each applicant is a member, amount of benefits to be granted, rate of stated periodical contributions which shall be sufficient to meet the requirements of subsection (1) of Section 83-29-19, nor until it shall be shown to the commissioner of insurance by the sworn statement of the treasurer or corresponding officer of such society that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly payment as herein provided for One Thousand Dollars ($1,000.00) of indemnity to be effected, which payments in the aggregate shall amount to at least Twenty-five Hundred Dollars ($2500.00); all of which shall be credited to the mortuary or disability fund on account of such applicants, and no part of which may be used for expenses.

Said advanced payments shall, during the period of organization, be held in trust and, if the organization is not completed within one (1) year as hereinafter provided, returned to said applicants.

The commissioner of insurance may make such examination and require such further information as he deems advisable, and upon presentation of satisfactory evidence that the society has complied with all the provisions of law, he shall issue to such society a certificate to that effect. Such certificate shall be prima facie evidence of the existence of such society at the date of such certificate. The commissioner of insurance shall cause a record of such certificate to be made, and a certified copy of such record may be given in evidence with like effect as the original certificate.

No preliminary certificate granted under the provisions of this section shall be valid after one (1) year from its date, or after such further period, not exceeding one (1) year, as may be authorized by the commissioner of insurance, upon cause shown, unless the five hundred (500) applicants herein required have been secured and the organization has been completed as herein provided. The articles of incorporation and all proceedings thereunder shall become null and void in one (1) year from the date of said preliminary certificate, or at the expiration of said extended period, unless such society shall have completed its organization and commenced business as herein provided. When any domestic society shall have discontinued business for the period of one (1) year, or has less than four hundred (400) members, its charter shall become null and void.

Every such society shall have the power to make a constitution and bylaws for the government of the society, the admission of its members, the management of its affairs, and the fixing and readjusting of the rates of contribution of its members from time to time; and it shall have the power to change, alter, add to, or amend such constitution and bylaws and have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

**SOURCES: Codes, 1930, § 5241; 1942, § 5755.**

**Cross References —** Fraternal benefit society defined, see § 83-29-1.

**RESEARCH REFERENCES**

**ALR.** Right of benevolent or fraternal society or organization against use of same or similar name, insignia, or ritual by another organization. 76 A.L.R.2d 1396.

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 8 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Form 81 (complaint, petition, or declaration-for injunction-to enjoin rival organization's use of name, titles, and other paraphernalia).

2B Am. Jur. Legal Forms 2d, Associations and Clubs §§ 27:5 et seq. (formation).

**CJS.** 10 C.J.S., Beneficial Associations §§ 7 et seq.

## § 83-29-23. Powers retained.

Any society now engaged in transacting business in this state may exercise all of the rights conferred hereby and all of the rights, powers, and privileges now exercised or possessed by it under its charter or articles of incorporation not inconsistent with this chapter, if incorporated. Any such domestic society may, upon filing notice thereof with the commissioner of insurance, be deemed from and after the date of filing such notice to be fully organized under the provisions of this chapter or, if it be a voluntary association, it may incorporate hereunder. No society already organized shall be required to reincorporate hereunder, and any such society may amend its articles of incorporation from time to time in the manner provided therein or in its constitution and laws. All such amendments shall be filed with the commissioner of insurance and shall become operative upon such filing, unless a later time be provided in such amendments or in its articles of incorporation, constitution, or laws.

**SOURCES: Codes, 1930, § 5242; 1942, § 5756.**

## § 83-29-25. Mergers and transfers.

No domestic society shall merge with or accept the transfer of the membership or funds of any other society unless such merger or transfer is evidenced by a contract in writing, setting out in full the terms and conditions of such merger or transfer and filed with the commissioner of insurance of this state, together with a sworn statement of the financial condition of each of said societies by its president and secretary, or corresponding officers, and a certificate of such officers, duly verified under oath of said officers of each of the contracting societies, that such merger or transfer has been approved by a majority of the votes cast by the members of the supreme legislative or governing body of each of the said societies.

Upon the submission of said contract, financial statements, and certificates, the commissioner of insurance shall examine the same and, if he shall find such financial statements to be correct and the said contract to be in conformity with the provisions of this section and that such merger or transfer is just and equitable to the members of each of said societies, he shall approve said merger or transfer, issue his certificate to that effect, and thereupon the said contract of merger or transfer shall be of full force and effect.

**SOURCES: Codes, 1930, § 5243; 1942, § 5757.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 9.

**CJS.** 10 C.J.S., Beneficial Associations § 12.

## § 83-29-27. Annual license.

Societies which are now authorized to transact business in this state may continue such business until the first day of January next succeeding the adoption of this chapter, and the authority of such societies may hereafter be renewed annually, but in all cases to terminate on the first day of the succeeding January; provided, however, the license shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the Commissioner of Insurance the fees prescribed in Sections 27-15-83 and 83-5-75.

**SOURCES: Codes, 1930, § 5244; 1942, § 5758; Laws, 1978, ch. 441, § 3; Laws, 2002, ch. 327, § 1, eff from and after July 1, 2002.**

**Cross References** — Term of license of insurance company, see § 83-5-71.
Annual license and fees for larger fraternal benefit societies, see § 83-30-53.

## § 83-29-29. Admission of foreign society.

No foreign society not now authorized to transact business in this state shall transact any business herein without a license from the commissioner of insurance. Any such society shall be entitled to transact business within this state upon filing with the commissioner a duly certified copy of its charter or articles of association; a copy of its constitution and laws, certified by its secretary or corresponding officer; a power of attorney to the commissioner as hereinafter provided; the last annual statement of its business, under oath of its president and secretary or corresponding officers, in the form required by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state satisfactory to the commissioner of insurance of this state; a certificate from the proper official in its home state, province, or country that the society is legally organized; a copy of its insurance contracts, which must show that benefits are provided for by periodical or other payments by persons holding similar contracts; and upon furnishing the commissioner such other information as he may deem necessary to a proper exhibit of its business and plan of working, and upon showing that its assets are invested in accordance with the laws of the states, territory, district, province, or country where it is organized, he shall issue a license to such society to do business in this state until the first day of the succeeding March. Such license shall, upon compliance with the provisions of this chapter, be renewed annually, but in all cases to terminate on the first day of the succeeding March; provided, however, that license shall continue in full force and effect until the new license be issued or specifically refused. Any foreign society desiring admission to this state shall have the qualifications required of domestic societies organized under this chapter, upon a valuation by any one of the standards authorized in this chapter, and shall at the same time possess net cash assets of not less than One Hundred Thousand Dollars ($100,000.00), or net cash assets of not less than Fifty Thousand Dollars ($50,000.00) with also invested assets of not less than One Hundred Thousand Dollars ($100,000.00), and in each case with additional contingent assets of not less than Three Hundred Thousand Dollars ($300,000.00); and shall have its assets invested as required by the laws of the state, territory, district, country, or province where it is organized. For each such license or renewal the society shall pay the commissioner Twenty-five Dollars ($25.00). When the commissioner refuses to license any society, or revokes its authority to do business in this state, he shall reduce his ruling, order, or decision to writing and file the same in his office, and shall furnish a copy thereof, together with a statement of his reason, to the officers of the society, upon request. Nothing contained in this, or the preceding section, or in this chapter, shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business therein, and such society shall have full right and authority to continue to collect payments from its members, to carry out its contracts, and to perform all the usual functions of said society except that of acquiring and admitting new members in this state after it has either been refused a renewal of its license herein or has voluntarily relinquished said license. Such activities on its part shall not be construed as doing business in said state so as to subject it to any fee, demand, or charge whatsoever from the insurance department or other agency of this state.

**SOURCES: Codes, 1930, § 5245; 1942, § 5759; Laws, 1946, ch. 358, § 1.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 24, 25, 64, 145 to 147.

**CJS.** 10 C.J.S., Beneficial Associations §§ 5, 18.

## § 83-29-31. Power of attorney and service of process.

Every society, whether domestic or foreign, now transacting business in this state and every such society hereafter applying for admission shall, before being licensed, appoint in writing the Commissioner of Insurance and his successors in office to be its true and lawful attorney on whom all legal process in any action or proceeding against it shall be served, and in such writing shall agree that any lawful process against it which is served upon such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state.

Copies of such appointment, certified by the Commissioner of Insurance, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted. Service shall only be made upon such attorney, shall be made in duplicate upon the Commissioner of Insurance or, in his absence, upon the person in charge of his office, and shall be deemed sufficient service upon such society. No such service shall be valid or binding against any such society when it is required thereunder to file its answer, pleading, or defense in less than thirty (30) days from the date of mailing the copy of the service to the society. When legal process against any such society is served upon the Commissioner of Insurance, he shall forthwith forward by certified mail one of the duplicate copies prepaid and directed to the secretary or corresponding officer. Legal process shall not be served upon any such society except in the manner provided herein.

**SOURCES: Codes, 1930, § 5246; 1942, § 5760; Laws, 2001, ch. 433, § 4, eff from and after July 1, 2001.**

**Cross References —** Notification of foreign company following service of process upon commissioner as its attorney, see § 83-5-11.

Appointment of commissioner as attorney for service of process before sale of insurance stock, see § 83-5-19.

Fee for service of process upon commissioner as attorney, see § 83-5-73.

Appointment of commissioner as attorney for service of process before admission of foreign insurance company, see § 83-21-1.

### JUDICIAL DECISIONS

**1. In general.**

In action on fraternal life policy, defendant could not complain of alleged error in refusing to quash summonses against defendant where defendant appeared and defended action, and hence was not prejudiced by alleged error. Afro-American Sons & Daughters v. Webster, 172 Miss. 602, 161 So. 318 (1935).

Service of process may be had, on foreign trainmen's brotherhood doing insurance business in state without having designated insurance commissioner as agent for process, in same manner as other foreign corporation doing business in state. Brotherhood of R.R. Trainmen v. Agnew, 170 Miss. 604, 155 So. 205 (1934).

Service on officer of local lodge, through whom association dealt, held sufficient. Brotherhood of R.R. Trainmen v. Agnew, 170 Miss. 604, 155 So. 205 (1934).

Brotherhood of Railroad Trainmen, an unincorporated association, held suable in its own name. Varnado v. Whitney, 166 Miss. 663, 147 So. 479 (1933).

## § 83-29-33. Place of meeting.

Any domestic society may provide that the meetings of its legislative or governing body may be held in any state, district, province, or territory wherein such society has subordinate branches, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state; but its principal office shall be located in this state.

**SOURCES: Codes, 1930, § 5247; 1942, § 5761.**

### RESEARCH REFERENCES

**CJS.** 10 C.J.S., Beneficial Associations § 29.

## § 83-29-35. No personal liability.

Officers and members of the supreme, grand, or any subordinate body of any such incorporated society shall not be individually liable for the payment of any disability or death benefit provided in the laws and agreements of such society; but the same shall be payable only out of the funds of such society and in the manner provided by its laws.

**SOURCES: Codes, 1930, § 5248; 1942, § 5762.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 30.

6 Am. Jur. Proof of Facts 3d, Civil Liability of Member or Officer of Unincorporated Association, §§ 1 et seq.

## § 83-29-37. Waiver of the provisions of the laws.

The constitution and laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws and constitution of the society, and the same shall be binding on the society and each and every member thereof and on all beneficiaries of members. No custom or course of conduct in violation of any of the provisions of the laws and constitution of the society shall be held to constitute waiver or estoppel on the part of the society.

**SOURCES: Codes, 1930, § 5249; 1942, § 5763.**

### JUDICIAL DECISIONS

**1. In general.**

Notice of an insured's disability to the local collection agent of a fraternal insurance society was not in compliance with, or a waiver of, the mandate of the society's constitution as to how claims should be propounded and to whom. Columbian Mut. Life Ins. Co. v. Eaves, 185 Miss. 127, 185 So. 557 (1939).

As to change of beneficiary, neither local secretary nor any other officer of local camp had right to waive any provisions in benefit certificate or constitution and laws of society, where constitution withheld such power. Sovereign Camp, Woodmen of the World v. Valentine, 170 Miss. 707, 155 So. 192 (1934).

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 11-14.

**CJS.** 10 C.J.S., Beneficial Associations §§ 27, 28.

## § 83-29-39. Benefit not attachable.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any such society shall be liable to attachment, garnishment, or other process, or be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary or any other person who may have a right thereunder, either before or after payment.

**SOURCES: Codes, 1930, § 5250; 1942, § 5764.**

**Cross References —** Exemption from seizure under execution or attachment of proceeds of life insurance policy, see §§ 85-3-11 et seq.

## § 83-29-41. Constitution and laws.

Every society transacting business under this chapter shall file with the commissioner of insurance a duly certified copy of all amendments of or additions to its constitution and laws within ninety days (90) after the enactment of the same. Printed copies of the constitution and laws as amended, changed, or added to, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

**SOURCES: Codes, 1930, § 5251; 1942, § 5765.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 15 et seq.

**CJS.** 10 C.J.S., Beneficial Associations § 29.

## § 83-29-43. Annual reports.

(1) Every society transacting business in this state shall annually, on or before the first day of March, file with the commissioner of insurance, in such form as he may require, a statement under oath of its president and secretary, or corresponding officers, of its condition and standing on the thirty-first day of December last preceding and of its transactions for the year ending on that date, and also shall furnish such other information as the commissioner may deem necessary to a proper exhibit of its business and plan of working. The commissioner may at other times require any further statement he may deem necessary to be made relating to such society, for the elucidation of any items in such annual report.

In addition to the annual report herein required, every society shall report annually to the commissioner of insurance on or before the first day of March a valuation by a competent actuary of its certificates in force on the thirty-first day of December last preceding. This valuation shall not be considered or regarded as a test of the financial solvency of the society, but as an indication of the ability of the society to pay the benefits promised under its certificates without change in benefits or in rates of contribution; and each society shall be held to be legally solvent as long as the funds belonging to the society are equal to or in excess of its matured liabilities. For the purposes of this valuation, the society may divide the certificates in its life insurance department into classes or sections according to the rates of contribution charged from time to time.

The method of valuation used shall be such as to produce not less than the net level premium reserves or, if part or the whole of the first year's contributions is used for expenses, the reserve according to the full preliminary term method of valuation or, as to all business hereafter written, the reserve according to the Illinois standard of valuation, the net premiums valued being the net premiums according to the valuation basis used, with due regard to the method used by the society in computing the member's age at entry or at re-rating. If, due to a readjustment or to a change of a member's plan of insurance, the regular rate of contribution paid by the member is lower than the regular rate of contribution he should have paid according to his attained age at the date of readjustment or change of plan of insurance, an additional reserve shall be set up equal to the additional liability caused by the payment of such reduced regular rate of contribution. If a member is paying a regular rate of contribution which is used solely for the payment of benefits, which is in excess of the valuation net premium according to the member's age at entry, or at re-rating, credit may be taken in the valuation for such regular contributions to an amount not greater than the present value of the benefits promised the said member, as at the date of valuation.

The table of mortality used in the valuation shall be the national fraternal congress table of mortality as adopted by the national fraternal congress August 23, 1899, or any other table of mortality recognized by the law of any state as a legal basis for the computation of premiums or reserves for life insurance companies or fraternal societies, or at its option a society may use a table based on its own experience of at least twenty (20) years and covering not less than one hundred thousand (100,000) lives, provided the mortality table used shall reasonably represent the actual mortality experience of the society. The tables used for the valuation of benefits dependent upon total and permanent disability shall be tables based upon reliable experience, and the society may value its life insurance benefits and disability benefits as one contract or may value such benefits separately.

The rate of interest used in the valuation shall not be greater than the average net rate which the society earned on its admitted assets during the five (5) years immediately preceding the date of the valuation.

Any society which shall show by the above method of valuation at four percent (4%) interest per annum or less that the admitted assets belonging to its life insurance department, or any class or section thereof, are at least equal to the reserve determined by the valuation of the certificates of such department, or class or section thereof, together with accrued liabilities under such certificates, may grant to the members in such department, or class or section thereof, any form of withdrawal equities or surrender values, not greater in value in any individual case than the reserve under the certificate, or make loans to them not greater than the value of such withdrawal equities or surrender values, and may make distribution of such portion of the surplus over and above such reserves and accrued liabilities, or may transfer such portion of the said surplus to the assets belonging to any other class or section of the society as may be determined by its board of directors or trustees upon the advice of its actuary.

A report of such valuation and an explanation of the facts concerning the condition of the society, of each class or section, thereby disclosed shall be printed and mailed to each beneficiary member of the society not later than June 1st of each year; or, in lieu thereof, such report of valuation and showing of the society's condition as thereby disclosed may be published in the society's official paper and the issue containing the same mailed to each beneficiary member of the society. The laws of such society shall provide that if the stated periodical contributions of the members are insufficient to pay all matured death and disability claims in full and to provide for the creation and maintenance of the funds required by its laws, additional, increased, or extra rates of contribution shall be collected from the members to meet such deficiency. Such laws may provide that, upon the written application or consent of the member, his certificate may be charged with its proportion of any deficiency disclosed by valuation, with interest not exceeding five percent (5%) per annum.

(2) In lieu of the requirements of subsection (1) of this section, any society now licensed in this state may, prior to ________, file its election, and

thereafter, until it shall rescind such action, it may value its certificates on a basis herein designated "accumulation basis" by crediting each member with the net amount contributed for each year and with interest at approximately the net rate earned and by charging him with his share of the losses for each year, herein designated "cost of insurance", and carrying the balance, if any, to his credit. The charge for the cost of insurance may be according to the actual experience of the society applied to a table of mortality recognized by the law of this state, and shall take into consideration the amount at risk during each year, which shall be the amount payable at death less the credit to the member. Except as specifically provided in its articles or laws or contracts, no charge shall be carried forward from the first valuation hereunder against any member for any past share of losses exceeding the contribution and credit. Any excess share of losses chargeable to any member may be paid out of a fund or contributions especially created or required for such purpose. Any member may transfer to any plan adopted by the society with net rates on which tabular reserves are maintained, and on such transfer shall be entitled to make such application of his credit as provided in the laws of the society. Certificates issued, created, or readjusted on a basis providing for adequate rates with adequate reserves to mature such certificates upon assumption for mortality and interest recognized by the law of this state shall be valued on such basis, herein designated the "tabular basis", provided that if on the first valuation under this section a deficiency in reserve shall be shown for any such certificate, the same shall be valued on the accumulation basis. Whenever in any society having members upon the tabular basis and upon the accumulation basis, the total of all costs of insurance provided for any year shall be insufficient to meet the actual death and disability losses for the year, the deficiency shall be met for the year from the available funds after setting aside all credits in the reserve, or from increased contribution, or by an increase in the number of assessments applied to the society as a whole or to classes or members as may be specified in its laws. Savings from a lower amount of death losses may be returned in like manner as may be specified in its laws. If the laws of the society so provide, the assets representing the reserves of any separate class of members may be carried separately for such class as if in an independent society, and the required reserve accumulation of such class so set apart shall not thereafter be mingled with the assets of other classes of the society. A table showing the credits to individual members for each age and year of entry and showing opposite each credit the tabular reserve required on the whole life, or other plan of insurance specified in the contract, according to assumption for mortality and interest recognized by the law of this state and adopted by the society, shall be filed by the society with each annual report and also be furnished to each member before July 1st of each year. In lieu of the aforesaid statement, there may be furnished to each member within the same time a statement giving the credit for such member and giving the tabular reserve and level rate required for a transfer carrying out the plan of insurance specified in the contract. No table or statement need be made or furnished where the reserves are maintained on the tabular basis. For this purpose, individual bookkeeping accounts for each member shall not be required, and all calculations may be made by actuarial methods. Nothing herein contained shall prevent the maintenance of such surplus over and above the credits on the accumulation basis and the reserves on the tabular basis as the society may provide by or pursuant to its laws; nor to be construed as giving to the individual member any right or claim to any such reserve or credit other than in manner as expressed in the contract and its laws; nor as making any such reserve or credits a liability in determining the legal solvency of the society.

**SOURCES: Codes, 1930, § 5252; 1942, § 5766.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance § 96.

## § 83-29-45. Examination of domestic societies.

The commissioner of insurance, or any person or persons he may appoint, shall have the power of visitation and examination into the affairs of any domestic society. They shall have free access to all the books, papers, and documents that relate to the business of the society.

The expenses of such examination shall be paid by the society examined, upon statement furnished by the commissioner of insurance, and the examination shall be made not oftener than once in three (3) years, except in case the commissioner shall find an emergency therefor.

Whenever after examination the commissioner of insurance is satisfied that any domestic society has failed to comply with any provisions of this chapter, or is exceeding its powers, or is not carrying out its contracts in good faith, or is transacting business fraudulently, or whenever any domestic society, after the existence of one year or more, shall have a membership of less than four hundred (400) or shall determine to discontinue business, the commissioner of insurance may present the facts relating thereto to the attorney general, who shall, if he deem the circumstances warrant, commence an action in quo warranto in a court of competent jurisdiction. Such court shall thereupon notify the officers of such society of a hearing, and if it shall then appear that such society should be closed, said society shall be enjoined from carrying on any further business; and some person shall be appointed receiver of such society and shall proceed at once to take possession of the books, papers, moneys, and other assets of the society and shall forthwith, under the direction of the court, proceed to close the affairs of the society and to distribute its funds to those entitled thereto.

**SOURCES: Codes, 1930, § 5253; 1942, § 5767.**

RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 143 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 43 (complaint or declaration, in nature of quo warranto, for order appointing receiver for insurance company and enjoining transaction of business).

**CJS.** 10 C.J.S., Beneficial Associations §§ 15 et seq.

## § 83-29-47. Application for receiver, etc.

No application for injunction against or proceeding for the dissolution of or the appointment of a receiver for any such domestic society or branch thereof shall be entertained by any court in this state unless the same is made by the attorney general or the commissioner of insurance.

**SOURCES: Codes, 1930, § 5254; 1942, § 5768; Laws, 1938, ch. 195.**

RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 145 to 147.

**CJS.** 10 C.J.S., Beneficial Associations § 16.

## § 83-29-49. Examination of foreign societies.

The commissioner of insurance, or any person or persons whom he may appoint, may examine any foreign society transacting or applying for admission to transact business in this state. They shall have free access to all the books, papers, and documents that relate to the business of the society. He may, in his discretion, accept in lieu of such examination the latest examination of the insurance department of the state, territory, district, province, or country where such society is organized. The expenses of making any such examination shall be paid by the society upon statement furnished by the commissioner of insurance.

If any such society or its officers refuse to submit to such examination or to comply with the provisions of the section relative thereto, the authority of such society to write new business in this state shall be suspended or license refused until satisfactory evidence is furnished the commissioner relating to the condition and affairs of the society, and during such suspension the society shall not write new business in this state.

**SOURCES: Codes, 1930, § 5255; 1942, § 5769.**

**Cross References —** Examination by commissioner of financial condition of foreign insurance company, see § 83-5-79.

## § 83-29-51. No adverse publications.

Pending, during, or after an examination or investigation of such society, either domestic or foreign, the commissioner of insurance shall make public no financial statement, report, or finding, nor shall he permit to become public any financial statement, report, or finding affecting the status, standing, or rights of any such society until a copy thereof shall have been served upon such society, at its home office; nor until such society shall have been afforded a reasonable opportunity to answer any such financial statement, report, or finding and to make such showing in connection therewith as it may desire.

**SOURCES: Codes, 1930, § 5256; 1942, § 5770.**

## § 83-29-53. Revocation of license.

When the commissioner of insurance on investigation is satisfied that any foreign society transacting business under this chapter has exceeded its powers, or has failed to comply with any provisions of this chapter, or is conducting business fraudulently, or is not carrying out its contracts in good faith, he shall notify the society of his findings and state in writing the grounds of his dissatisfaction, and after reasonable notice require said society, on a date named, to show cause why its license should not be revoked. If on the date named in said notice such objections have not been removed to the satisfaction of the said commissioner or the society does not present good and sufficient reasons why its authority to transact business in this state should not at that time be revoked, he may revoke the authority of the society to continue business in this state. All decisions and findings of the commissioner made under the provisions of this section may be reviewed by proper proceedings in any court of competent jurisdiction.

**SOURCES: Codes, 1930, § 5257; 1942, § 5771.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance § 124.

## § 83-29-55. Certain societies not affected.

Nothing contained in this chapter shall be construed to affect or apply to grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias exclusive of the insurance department of the supreme lodge Knights of Pythias, and the Junior Order of United American Mechanics exclusive of beneficiary degree or insurance branch of the National Council Junior Order United American Mechanics, or societies which admit to membership only persons engaged in one or more hazardous occupation in the same or similar lines of business. The commissioner of insurance may require from any society such information as will enable him to determine whether such society is exempt from the provisions of this chapter.

Any fraternal benefit society heretofore organized and incorporated and operating within the definition set forth in Sections 83-29-1, 83-29-3, and 83-29-5, providing for benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this chapter, and shall have all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter as to valuations of benefit certificates shall not apply to such society.

**SOURCES: Codes, 1930, § 5258; 1942, § 5772; Laws, 1938, ch. 192.**

## § 83-29-57. Taxation.

Every fraternal benefit society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution; and all of its funds shall be exempt from all and every state, county, district, municipal and state tax other than insurance license taxes as defined by Section 27-15-83 and ad valorem taxes on real estate, office equipment and motor vehicles.

**SOURCES: Codes, 1930, § 5259; 1942, § 5773; Laws, 1978, ch. 441, § 7, eff from and after July 1, 1978.**

**Cross References** — Homestead exemption for property of a fraternal or benevolent organization, see §§ 27-33-17, 27-33-19.

Exemption of larger fraternal benefit society funds from taxation, see § 83-30-47.

### RESEARCH REFERENCES

**Am Jur.** 71 Am. Jur. 2d, State and Local Taxation §§ 330, 331.

**CJS.** 84 C.J.S., Taxation §§ 300, 301.

## § 83-29-59. Penalties.

Any person, officer, member, or examining physician of any society authorized to do business under this chapter who shall knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any application for membership, or for the purpose of obtaining money from or benefit in any society transacting business under this chapter, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), or imprisonment in the county jail for not less than thirty (30) days nor more than one (1) year, or both, in the discretion of the court. Any person who shall willfully make a false statement of any material fact or thing in a sworn statement as to the death or disability of a certificate holder in any such society for the purpose of procuring payment of a benefit named in the certificate of such holder, and any person who shall willfully make any false statement in any verified report or declaration under oath required or authorized by this chapter, shall be guilty of perjury and shall be proceeded against and punished as provided by the statutes of this state in relation to the crime of perjury.

Any person who shall solicit membership for, or in any manner assist or procure membership in, any fraternal benefit society not licensed to do business in this state, or who shall solicit membership for, or in any manner assist in procuring membership in, any such society not authorized as herein provided to do business as herein defined in this state, shall be punished by a fine of not less than Fifty Dollars ($50.00) nor more than Two Hundred Dollars ($200.00).

Any society, or any officer, agent, or employee thereof neglecting or refusing to comply with, or violating any of the provisions of this chapter, the penalty for which neglect, refusal, or violation is not specified in this section, shall be fined not exceeding Two Hundred Dollars ($200.00) upon conviction thereof.

**SOURCES: Codes, 1930, § 5260; 1942, § 5774.**

**Cross References —** Perjury, see §§ 97-9-59 through 97-9-65.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 69.

**CJS.** 44 C.J.S., Insurance § 139.

## § 83-29-61. Fraternal benefit societies must give bond.

All fraternal benefit societies domiciled in or incorporated under the laws of Mississippi, or whose principal place of business is therein, shall be required to give a bond in some surety company licensed in Mississippi or in approved securities consisting of bonds of some municipality, county, levee board, or of the State of Mississippi. The minimum of said bond or securities shall be Two Hundred and Fifty Dollars ($250.00) for a minimum membership of two hundred (200), and to increase in sums of Two Hundred and Fifty Dollars ($250.00) for each two hundred (200) additional members, or fraction thereof, until it amounts to the maximum sum of Ten Thousand Dollars ($10,000.00).

**SOURCES: Codes, Hemingway's 1917, § 5206; 1930, § 5261; 1942, § 5775; Laws, 1916, ch. 204.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 72.

**CJS.** 44 C.J.S., Insurance § 39.

## § 83-29-63. Suit and judgment on bond.

Said bond shall be conditioned to pay any judgment entered up against any such society in any court of competent jurisdiction in this state, and such judgment shall be a lien upon the bond or securities. The judgment creditor shall have the right to bring suit on said bond for the satisfaction of the judgment in the county in which the judgment is rendered. If the present bylaws of such societies provide for the payment of beneficiaries the sum received from one (1) monthly assessment, nothing herein shall amend or annul the terms of such policies, provided that all beneficiaries shall be paid within ninety (90) days after proof of death has been filed with the proper officer of the society, that said assessments shall be made each month to cover the deaths occurring during the preceding months, and that the funds secured from such monthly assessments shall be kept separately and the total amount of each monthly assessment shall be clearly shown on the book account, together with the names of the beneficiaries and the amount due them; provided, that societies may levy extra assessments to pay claims already due.

One or more suits on the bond herein required shall not vitiate the bond or prevent additional recovery thereon; but when judgments shall be recovered to the amount of the bond, the insurance commissioner shall require an additional bond.

**SOURCES: Codes, Hemingway's 1917, § 5207; 1930, § 5262; 1942, § 5776; Laws, 1916, ch. 204.**

**Cross References** — Definition of insurance contract, see § 83-5-5.

Revocation of license of insurance company for unsatisfied judgment, see § 83-5-21.

### JUDICIAL DECISIONS

**1. In general.**

Brotherhood of Railroad Trainmen, an unincorporated association, is suable in its own name. Varnado v. Whitney, 166 Miss. 663, 147 So. 479 (1933).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

**CJS.** 44 C.J.S., Insurance §§ 105-115, 129, 130.

## § 83-29-65. Society must make up all delinquencies.

Domestic societies delinquent with their beneficiaries for death claims must show an improvement by annually decreasing the amount of same not less than five percent (5%). Failure to do so shall subject them to a revocation of their license.

**SOURCES: Codes, Hemingway's 1917, § 5208; 1930, § 5263; 1942, § 5777; Laws, 1916, ch. 204.**

RESEARCH REFERENCES

**ALR.** Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts. 47 A.L.R.3d 314.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance § 124.

## § 83-29-67. Separate expense fund must be provided.

All fraternal societies incorporated under the laws of this state, or operating herein, or whose principal place of business is in this state, shall provide a separate fund from which to pay expenses, which shall not exceed for established societies more than twenty percent (20%) of total collections, nor more than twenty-five percent (25%) during the period of organization. Where practicable, the mortality funds shall be kept separate from other funds and be used only for the purpose of paying death benefits.

**SOURCES: Codes, Hemingway's 1917, § 5209; 1930, § 5264; 1942, § 5778; Laws, 1916, ch. 204; Laws, 1940, ch. 207.**

RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

**CJS.** 10 C.J.S., Beneficial Associations § 32.

## § 83-29-69. Authority of fraternal orders revoked for failure to pay judgments.

If a judgment shall be rendered by any court in this state against any fraternal order and such judgment shall not be paid and satisfied within ninety (90) days after the same shall have become final, it shall be the imperative duty of the insurance commissioner, immediately upon being advised that such judgment has not been paid or satisfied within the time named, to revoke any and every authority granted to such fraternal order, or any agent thereof, to transact any business in this state. No such fraternal order, or agent thereof, shall thereafter transact any business in this state until again duly licensed, and in case of such revocation no renewal license or certificate of authority to transact business in this state shall be granted to such fraternal order for three (3) years after such revocation. Whenever such license or certificate of authority shall be revoked, the insurance commissioner shall publish such revocation in some newspaper published in this state.

**SOURCES: Codes, Hemingway's 1917, § 5210; 1930, § 5265; 1942, § 5779; Laws, 1912, ch. 173.**

**Cross References** — Revocation of license of insurance company for unsatisfied judgment, see § 83-5-21.

Revocation of authority of domestic insurance company to transact new business on ground of impairment of capital, see § 83-19-57.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance § 124.

## § 83-29-71. Conversion of fraternal benefit societies into stock companies.

Any fraternal benefit society organized and doing business under the laws of this state may be converted into a stock life or stock life and disability company upon the terms and conditions as follows:

Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by a two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular stock life or stock life and disability company shall be to the best interest of the society and its members, or when a majority of the members in good standing of any such domestic fraternal benefit society shall in writing signify their desire for such conversion, or in event the supreme governing legislative body of any fraternal benefit society prior to the adoption of this chapter has by proper resolution expressed its desire and purpose to change or convert said society into a level premium life insurance company, then in either event said fraternal benefit society may adopt and file with the insurance commissioner of Mississippi an amendment or amendments to its articles of incorporation authorizing it to change or convert from a fraternal to a domestic stock life or stock life and disability company; and said amendment shall become operative upon its approval by the insurance commissioner unless a later time be provided in said amendment. If the amendment is approved by the insurance commissioner, he shall issue his certificate of approval in writing. Thereafter the company shall have legal existence as a domestic stock life or stock life and disability company as indicated by the amendment, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and be subject to all laws defining the powers and providing for the regulation of stock life insurance companies.

Provided, however, that no such conversion from a fraternal benefit society to a regular stock or disability company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to every member of such fraternal benefit society at his last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by the supreme governing body; but the notice provided herein shall not apply to or be required of any fraternal society whose district councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into a level premium life insurance or disability company before March 19, 1926, or when such proposed change to a stock life or stock life and disability company, before becoming effective, is submitted to and unanimously approved by the national council or supreme governing body of such fraternal society at a regular meeting of such national council or supreme governing body, or at a special meeting of the national council or supreme governing body called by the national or supreme president for the purpose of considering such proposal. The national or supreme president of any such fraternal benefit society may prepare in writing a ballot and, on ninety (90) days' written notice to each member, take a referendum vote in writing as to any such proposed change or conversion. If two thirds (⅔) of the membership by said referendum vote authorize the national council or supreme legislative governing body to change or convert the society into a stock life or stock life and disability company, then in that event the national council or supreme legislative governing body of said society may proceed to vote said change, and its action in the premises shall be binding upon all members. The amendment to the charter, the method of placing any surplus belonging to any such fraternal benefit society to capital stock, and the method of prorating the stock among the membership in a way to protect the interests of all policyholders and members, shall be under the jurisdiction of the insurance commissioner and subject to his approval.

**SOURCES: Codes, 1930, § 5266; 1942, § 5780; Laws, 1926, ch. 260.**

**Cross References —** Conversion of larger fraternal benefit society into mutual or stock insurer, see § 83-30-29.

Conversion of fraternal society into mutual life and disability insurance company, see § 83-31-15.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 15.

**CJS.** 10 C.J.S., Beneficial Associations § 9.

## § 83-29-73. Fraternal societies may insure children.

Any fraternal benefit society organized under the laws of this state, or doing business in this state, may issue certificates for the payment of sick, death, or annuity benefits upon the lives of children between the ages of one (1) and eighteen (18) years who have been examined and approved in accordance with the laws of such society, provided that the applications for such a benefit certificate shall be made by a parent or guardian of such child or some person upon whom the child is dependent for support. When such child shall arrive at the age permitting a personal application for insurance under the laws of the society, the certificate issued under this provision may be exchanged for any other form of certificate issued by the society, such exchange to be in accordance with the constitution, laws, and regulations of such society, the free designation of a beneficiary in such exchange being left to the child.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209el; 1930, § 5267; 1942, § 5781; Laws, 1918, ch. 212.**

**Cross References** — Authority for minors to contract for insurance, see § 83-7-19.

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 49.

**CJS.** 10 C.J.S., Beneficial Associations § 41.

## § 83-29-75. Conditions under which certificates to be issued.

Such society shall not issue any such benefit certificate until after it shall have simultaneously put in force at least five hundred (500) such certificates, on each of which at least one (1) assessment has been paid, nor where the number of lives represented by such certificate falls below five hundred (500).

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209fl; 1930, § 5268; 1942, § 5782; Laws, 1918, ch. 212.**

### RESEARCH REFERENCES

**Am Jur.** 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 22.

**CJS.** 10 C.J.S., Beneficial Associations § 30.

# CHAPTER 30

## Larger Fraternal Benefit Societies

| | | |
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### ARTICLE 1.

### STRUCTURE AND PURPOSE.

| SEC. | |
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| 83-30-1. | Larger fraternal benefit societies. |
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### § 83-30-1. Larger fraternal benefit societies.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of Section 83-30-73(1) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having more than Thirty Thousand Dollars ($30,000.00) in total annual written premium, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a larger fraternal benefit society.

**SOURCES: Laws, 2001, ch. 362, § 1, eff from and after July 1, 2001.**

**Cross References** — Fraternal benefit societies, see §§ 83-29-1 et seq.

### § 83-30-3. Lodge system.

(1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

**SOURCES: Laws, 2001, ch. 362, § 2, eff from and after July 1, 2001.**

**Cross References** — Definition of lodge system as it applies to fraternal benefit societies, see § 83-29-3.

## § 83-30-5. Representative form of government.

A society has a representative form of government when:

(a) It has a supreme governing body constituted in one of the following ways:

(i) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds (⅔) of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(ii) Direct Election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(b) The officers of the society are elected either by the supreme governing body or by the board of directors;

(c) Only benefit members are eligible for election to the supreme governing body and the board of directors; and

(d) Each voting member shall have one (1) vote; no vote may be cast by proxy.

**SOURCES: Laws, 2001, ch. 362, § 3, eff from and after July 1, 2001.**

**Cross References** — Definition of representative form of government as it applies to fraternal benefit societies, see § 83-29-5.

## § 83-30-7. Terms used.

Whenever used in this chapter:

(a) "Benefit contract" shall mean the agreement for provision of benefits authorized by Section 83-30-31, as that agreement is described in Section 83-30-37(1).

(b) "Benefit member" shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(c) "Certificate" shall mean the document issued as written evidence of the benefit contract.

(d) "Commissioner" shall mean the Commissioner of Insurance of this state.

(e) "Laws" shall mean the society's articles of incorporation, constitution and bylaws, however designated.

(f) "Lodge" shall mean subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

(g) "Premiums" shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(h) "Rules" shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(i) "Society" shall mean larger fraternal benefit society as defined in Section 83-30-1, unless otherwise indicated.

**SOURCES: Laws, 2001, ch. 362, § 4, eff from and after July 1, 2001.**

## § 83-30-9. Purposes and powers.

(1) A society shall operate for the benefit of members and their beneficiaries by:

(a) Providing benefits as specified in Section 83-30-31; and

(b) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

**SOURCES: Laws, 2001, ch. 362, § 5, eff from and after July 1, 2001.**

## ARTICLE 3.

## MEMBERSHIP.

SEC.

83-30-11. Qualifications for membership.

83-30-13. Location of office, meetings, communications to members, grievance procedures.

83-30-15. No personal liability.

83-30-17. Waiver.

### § 83-30-11. Qualifications for membership.

(1) A society shall specify in its laws or rules:

(a) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) and not greater than age twenty-one (21);

(b) The process for admission to membership for each membership class; and

(c) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

**SOURCES: Laws, 2001, ch. 362, § 6, eff from and after July 1, 2001.**

### § 83-30-13. Location of office, meetings, communications to members, grievance procedures.

(1) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one (1) subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2)(a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one (1) member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

**SOURCES: Laws, 2001, ch. 362, § 7, eff from and after July 1, 2001.**

## § 83-30-15. No personal liability.

(1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed (a) in relation to any matter in such action, suit or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society, or (b) in relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subsection (1) or (2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors and administrators.

(3) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director,

officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(4) No director, officer, employee, member or volunteer of a society serving without compensation, shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved willful or wanton misconduct.

**SOURCES: Laws, 2001, ch. 362, § 8, eff from and after July 1, 2001.**

## § 83-30-17. Waiver.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

**SOURCES: Laws, 2001, ch. 362, § 9, eff from and after July 1, 2001.**

## ARTICLE 5.

## GOVERNANCE.

SEC.
83-30-19. Organization.
83-30-21. Amendments to laws.
83-30-23. Institutions.
83-30-25. Reinsurance.
83-30-27. Consolidations and mergers.
83-30-29. Conversion of fraternal benefit society into a mutual or stock insurer.

## § 83-30-19. Organization.

A domestic society organized on or after July 1, 2001, shall be formed as follows:

(a) Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(i) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(ii) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;

(iii) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

(b) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the commissioner, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in such amount, not less than Three Hundred Thousand Dollars ($300,000.00), nor more than One Million Five Hundred Thousand Dollars ($1,500,000.00), as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain and file the articles of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(c) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the commissioner upon cause shown, unless the five hundred (500) applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(d) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(i) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(ii) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(iii) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(iv) It shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least One Hundred Fifty Thousand Dollars ($150,000.00). Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, as herein provided, such premiums shall be returned to said applicants.

(e) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The commissioner shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(f) Any incorporated society authorized to transact business in this state on July 1, 2001, shall not be required to reincorporate.

**SOURCES: Laws, 2001, ch. 362, § 10, eff from and after July 1, 2001.**

## § 83-30-21. Amendments to laws.

(1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one (1) of the methods herein specified.

(2) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner who shall approve such amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the commissioner shall disapprove any such amendment within sixty (60) days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the commissioner shall be forwarded in writing, and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disap-

proves such amendment, the reasons therefor shall be stated in such written notice.

(3) Within ninety (90) days from the approval thereof by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(4) Every foreign or alien society authorized to do business in this state shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of same.

(5) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

**SOURCES: Laws, 2001, ch. 362, § 11, eff from and after July 1, 2001.**

## § 83-30-23. Institutions.

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by Section 83-30-9(1)(b). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

**SOURCES: Laws, 2001, ch. 362, § 12, eff from and after July 1, 2001.**

## § 83-30-25. Reinsurance.

(1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner but no such society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after July 1, 2001, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding subsection (1) of this section, a society may reinsure the risks of another society in a consolidation, merger or assumption reinsurance transaction approved by the commissioner.

**SOURCES: Laws, 2001, ch. 362, § 13, eff from and after July 1, 2001.**

## § 83-30-27. Consolidations and mergers.

(1) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner, but not earlier than December 31 next preceding the date of the contract;

(c) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (⅔) vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(d) Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(2) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the commissioner, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the Commissioner of Insurance of such state or territory and a certificate of such approval filed with the commissioner.

(3) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

**SOURCES: Laws, 2001, ch. 362, § 14, eff from and after July 1, 2001.**

## § 83-30-29. Conversion of fraternal benefit society into a mutual or stock insurer.

(1) Any domestic fraternal benefit society organized and doing business under the laws of this state may be converted and licensed as a mutual life or mutual life and disability insurance company by compliance with all the requirements of Section 83-31-15.

(2) Any fraternal benefit society organized and doing business under the laws of this state may be converted into a stock like or stock life and disability company upon the terms and conditions as follows:

(a) Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by a two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular stock life or stock life and disability company shall be to the best interest of the society and its members, or when a majority of the members in good standing of any such domestic fraternal benefit society shall in writing signify their desire for such conversion, or in event the supreme governing legislative body of any fraternal benefit society prior to the adoption of this chapter has by proper resolution expressed its desire and purpose to change or convert said society into a level premium life insurance company, then in either event said fraternal benefit society may adopt and file with the commissioner an amendment or amendments to its articles of incorporation authorizing it to change or convert from a fraternal to a domestic stock life or stock life and disability company; and said amendment shall become operative upon its approval by the commissioner unless a later time be provided in said amendment. If the amendment is approved by the commissioner, he or she shall issue a certificate of approval in writing. Thereafter the company shall have legal existence as a domestic stock life or stock life and disability company as indicated by the amendment, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and subject to all laws defining the powers and providing for the regulation of stock life insurance companies.

(b) Provided, however, that no such conversion from a fraternal benefit society to a regular stock or disability company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to every member of such fraternal benefit society at their last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by the supreme governing body; but notice provided herein councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into a level premium life insurance or disability company at the time this chapter becomes effective or when such proposed change to a stock life or stock life and disability company, before becoming effective, is submitted to and unanimously approved by the national council or supreme governing body of such fraternal society at a regular meeting of such national council or supreme governing body, or a special meeting of the national council or supreme governing body called by the national or supreme president for the purpose of considering such proposal. The national or supreme president of any such fraternal benefit society may prepare in writing a ballot and, on ninety (90) days' written notice to each member, take a referendum vote in writing as to any such proposed change or conversion. If two-thirds (⅔) of the membership by said referendum vote authorize the national council or supreme legislative governing body to change or covert the society into a stock life or stock life and disability company, then in that event the national council or supreme legislative governing body of said society may proceed to vote said change, and its action in the premises shall be binding upon all members. The amendment to the charter, the method of placing any surplus belonging to any such fraternal benefit society to capital stock, and the method of prorating the stock among membership in a way to protect the interests of all policyholders and members, shall be under the jurisdiction and approval of the commissioner.

**SOURCES: Laws, 2001, ch. 362, § 15, eff from and after July 1, 2001.**

**Cross References —** Conversion of fraternal benefit society into stock company, see § 83-29-71.

Conversion of fraternal benefit society into mutual life and disability insurance company, see § 83-31-15.

## ARTICLE 7.

## CONTRACTUAL BENEFITS.

SEC.
83-30-31. Benefits.
83-30-33. Beneficiaries.
83-30-35. Benefits not attachable.
83-30-37. The benefit contract.
83-30-39. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

### § 83-30-31. Benefits.

(1) A society may provide the following contractual benefits in any form:

(a) Death benefits;

(b) Endowment benefits;

(c) Annuity benefits;

(d) Temporary or permanent disability benefits;

(e) Hospital, medical or nursing benefits;

(f) Funeral benefits;

(g) Monument or tombstone benefits to the memory of deceased members; and

(h) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

**SOURCES: Laws, 2001, ch. 362, § 16, eff from and after July 1, 2001.**

## § 83-30-33. Beneficiaries.

(1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

(3) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

**SOURCES: Laws, 2001, ch. 362, § 17, eff from and after July 1, 2001.**

## § 83-30-35. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

**SOURCES: Laws, 2001, ch. 362, § 18, eff from and after July 1, 2001.**

## § 83-30-37. The benefit contract.

(1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either (a) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (b) in lieu of or in combination with (a), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(5) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(6) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life and disability insurers in this state. Every life, accident and sickness, health or disability insurance certificate and every annuity certificate issued on or after one (1) year from July 1, 2001, must be filed with the commissioner and shall meet the standard contract provision

requirements not inconsistent with this chapter for like policies issued by life and disability insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(7) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(8) A society may specify the terms and conditions on which benefit contracts may be assigned.

**SOURCES: Laws, 2001, ch. 362, § 19, eff from and after July 1, 2001.**

## § 83-30-39. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

(1) For certificates issued prior to one (1) year after July 1, 2001, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to July 1, 2001.

(2) For certificates issued on or after one (1) year from July 1, 2001, for which reserves are computed on the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Table or the commissioner's 1958 Standard Ordinary Mortality Table, or the commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

**SOURCES: Laws, 2001, ch. 362, § 20, eff from and after July 1, 2001.**

## ARTICLE 9.

## FINANCIAL.

| SEC. | |
|---|---|
| 83-30-41. | Investments. |
| 83-30-43. | Funds. |
| 83-30-45. | Exemption from insurance laws. |
| 83-30-47. | Taxation. |

### § 83-30-41. Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers, and such securities shall be valued accordingly to the methods used in valuing similar securities held by life insurers. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this chapter for the investment of funds.

**SOURCES: Laws, 2001, ch. 362, § 21, eff from and after July 1, 2001.**

**Cross References —** Approved investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

Approved investments for assets of fraternal benefit societies, see § 83-29-17.

Approved investments for assets of mutual companies, see § 83-31-29.

### § 83-30-43. Funds.

(1) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(3) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which Section 83-30-37(2) and (4) shall not apply.

**SOURCES: Laws, 2001, ch. 362, § 22, eff from and after July 1, 2001.**

## § 83-30-45. Exemption from insurance laws.

Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. No law hereafter enacted shall apply to them unless they be expressly designated therein.

**SOURCES: Laws, 2001, ch. 362, § 23, eff from and after July 1, 2001.**

**Cross References —** Laws applicable to domestic insurance companies, see § 83-5-13.

Exclusion of fraternal benefit societies from insurance laws of state, see § 83-29-7.

Exclusion of fraternal societies from laws governing burial associations, see § 83-37-33.

## § 83-30-47. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from every state, county, district, municipal and state tax other than license taxes as defined by Section 27-15-83 and ad valorem taxes on real estate, office equipment and motor vehicles.

**SOURCES: Laws, 2001, ch. 362, § 24, eff from and after July 1, 2001.**

**Cross References —** Homestead exemption for property of a fraternal or benevolent organization, see §§ 27-33-17, 27-33-19.

Exemption of fraternal benefit society funds from taxation, see § 83-29-57.

### ARTICLE 11.

### REGULATION.

SEC.
83-30-49. Valuation.
83-30-51. Annual statement.
83-30-53. Annual license.
83-30-55. Examination of societies; no adverse publications.
83-30-57. Foreign or alien society — admission.
83-30-59. Injunction — liquidation — receivership of domestic society.
83-30-61. Suspension, revocation or refusal of license of foreign or alien society.
83-30-63. Injunction.
83-30-65. Licensing of agents.
83-30-67. Unfair methods of competition and unfair and deceptive acts and practices.

## § 83-30-49. Valuation.

(1) Standards of valuation for certificates issued prior to one (1) year after July 1, 2001, shall be those provided by the laws applicable immediately prior to July 1, 2001.

(2) The minimum standards of valuation for certificates issued on or after one (1) year from July 1, 2001, shall be based on the following tables:

(a) For certificates of life insurance — the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Mortality Table, the commissioner's 1958 Standard Ordinary Mortality Table, the commissioner's 1980 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurers;

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits — such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(3) The commissioner may, in his or her discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) Any society, with the consent of the Commissioner of Insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

**SOURCES: Laws, 2001, ch. 362, § 25, eff from and after July 1, 2001.**

## § 83-30-51. Annual statement.

(1) Every society transacting business in this state shall annually, on or before March 1, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(2) As part of the annual statement herein required, each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding, provided the commissioner may, in his or her discretion for cause shown, extend the time for filing such valuation for not

more than two (2) calendar months. Such valuation shall be done in accordance with the standards specified in Section 83-30-49. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society. This valuation shall not be considered or regarded as a test of the financial solvency of the society, but as an indication of the ability of the society to pay the benefits promised under its certificates without change in benefits or in rates of contribution; and each society shall be held to be legally solvent as long as the funds belonging to the society are equal to or in excess of its matured liabilities.

(3) A society neglecting to file the annual statement in the form and within the time provided by this section may be subject to a fine of One Hundred Dollars ($100.00) for each day during which such neglect continues, and its authority to do business in this state may be suspended by the commissioner while such default continues.

**SOURCES: Laws, 2001, ch. 362, § 26; Laws, 2003, ch. 315, § 3, eff from and after July 1, 2003.**

## § 83-30-53. Annual license.

Societies which are now authorized to transact business in this state may continue such business until the first day of January next succeeding July 1, 2003, and the authority of such societies may hereafter be renewed annually, but in all cases to terminate on the first day of the succeeding January. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the commissioner the fees prescribed in Sections 27-15-83 and 83-5-75.

**SOURCES: Laws, 2001, ch. 362, § 27; Laws, 2003, ch. 315, § 4, eff from and after July 1, 2003.**

**Cross References** — Annual license and fees for fraternal benefit societies, see § 83-29-27.

## § 83-30-55. Examination of societies; no adverse publications.

(1) The commissioner, or any person he or she may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

**SOURCES: Laws, 2001, ch. 362, § 28, eff from and after July 1, 2001.**

**Cross References** — Power of commissioner to examine insurers, see § 83-5-37. Examination of domestic insurance companies, see § 83-19-27.

## § 83-30-57. Foreign or alien society — admission.

No foreign or alien society shall transact business in this state without a license issued by the commissioner. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the commissioner:

(a) A duly certified copy of its charter or articles of incorporation;

(b) A copy of its bylaws, certified by its secretary or corresponding officer;

(c) A power of attorney to the commissioner as prescribed in Section 83-29-31;

(d) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner;

(e) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(f) Copies of its certificate forms; and

(g) Such other information as the commissioner may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this chapter.

**SOURCES: Laws, 2001, ch. 362, § 29; Laws, 2003, ch. 315, § 1, eff from and after July 1, 2003.**

## § 83-30-59. Injunction — liquidation — receivership of domestic society.

(1) When the commissioner upon investigation finds that a domestic society:

(a) Has exceeded its powers;

(b) Has failed to comply with any provision of this chapter;

(c) Is not fulfilling its contracts in good faith;

(d) Has a membership of less than four hundred (400) after an existence of one (1) year or more; or

(e) Is conducting business fraudulently or in a manner hazardous to its members, creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall simultaneously issue a written notice to the society requiring that the deficiency or deficiencies which exist be corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall take such action as is necessary and appropriate under Chapter 24 of Title 83.

(2) The commissioner may take such action as is necessary and appropriate under this section as respects a domestic society which shall voluntarily determine to discontinue business.

**SOURCES: Laws, 2001, ch. 362, § 30, eff from and after July 1, 2001.**

**Cross References** — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

## § 83-30-61. Suspension, revocation or refusal of license of foreign or alien society.

(1) When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(a) Has exceeded its powers;

(b) Has failed to comply with any of the provisions of this chapter;

(c) Is not fulfilling its contracts in good faith; or

(d) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction, and if the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(2) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

**SOURCES: Laws, 2001, ch. 362, § 31, eff from and after July 1, 2001.**

## § 83-30-63. Injunction.

No application for injunction against or proceeding for the dissolution of or the appointment of a receiver for any domestic society, or lodge thereof, or against any foreign or alien society, shall be entertained in any court of this state unless made by the Attorney General or the commissioner.

**SOURCES: Laws, 2001, ch. 362, § 32, eff from and after July 1, 2001.**

## § 83-30-65. Licensing of agents.

(1) Agents of societies shall be licensed in accordance with the provisions of Chapter 17 of Title 83.

(2) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

**SOURCES: Laws, 2001, ch. 362, § 33, eff from and after July 1, 2001.**

**Cross References** — Insurance agents, solicitors or adjusters, see §§ 83-17-1 et seq.

## § 83-30-67. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this state shall be subject to the provisions of Chapter 5 of Title 83 relating to unfair practices; provided, however, that nothing therein shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

**SOURCES: Laws, 2001, ch. 362, § 34, eff from and after July 1, 2001.**

**Cross References** — General provisions relative to insurance and insurance companies, see § 83-5-1 et seq.

## ARTICLE 13.

## MISCELLANEOUS PROVISIONS.

SEC.
83-30-69. Service of process.
83-30-71. Penalties.
83-30-73. Exemption of certain societies.
83-30-75. Review.
83-30-77. Severability.

## § 83-30-69. Service of process.

(1) Every society authorized to do business in this state shall appoint in writing the commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(2) Service shall only be made upon the commissioner, or if absent, upon the person in charge of his or her office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the commissioner, he shall forthwith forward the duplicate copy by certified mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided.

(3) At the time of serving any process upon the commissioner, the plaintiff or complainant in the action shall pay to the commissioner a fee of Twenty-five Dollars ($25.00).

**SOURCES: Laws, 2001, ch. 362, § 35; Laws, 2003, ch. 315, § 2, eff from and after July 1, 2003.**

## § 83-30-71. Penalties.

(1) A person who shall knowingly or willfully make any false or fraudulent statement or representation in or relating to any application for membership or for the purpose of obtaining money from or a benefit in any society, shall be guilty of a misdemeanor and upon conviction thereof be fined not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), or imprisonment in the county jail not less than thirty (30) days nor more than one (1) year, or both, in the discretion of the court.

(2) Any person who shall willfully make a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction thereof be fined not less than Fifty Dollars ($50.00) nor more than Two Hundred Dollars ($200.00).

(4) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this chapter for which a penalty is not otherwise prescribed shall upon conviction thereof be fined not exceeding Two Hundred Dollars ($200.00).

**SOURCES: Laws, 2001, ch. 362, § 36, eff from and after July 1, 2001.**

**Cross References —** Perjury generally, see §§ 99-9-59 through 99-9-65.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

## § 83-30-73. Exemption of certain societies.

(1) Nothing contained in this chapter shall be so construed as to affect or apply to grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias exclusive of the insurance department of the supreme lodge Knights of Pythias, and the Junior Order of United American Mechanics exclusive of beneficiary degree or insurance branch of the National Council Junior Order United American Mechanics, or societies which admit to membership only persons engaged in one or more hazardous occupation in the same or similar lines of business. The Commissioner of Insurance may require from any society such information as will enable him to determine whether such society is exempt from the provisions of this chapter.

(2) Any larger fraternal benefit society heretofore organized and incorporated and operating within the definition set forth in Section 83-30-1 providing benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this chapter, and shall have all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter as to valuations of benefit certificates shall not apply to such society.

(3) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this chapter.

(4) Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this state.

**SOURCES: Laws, 2001, ch. 362, § 37, eff from and after July 1, 2001.**

## § 83-30-75. Review.

All decisions and findings of the commissioner made under the provisions of this chapter shall be subject to review as set forth in Section 83-6-41 or otherwise in Title 83 as respects the particular subject matter involved.

**SOURCES: Laws, 2001, ch. 362, § 38, eff from and after July 1, 2001.**

**Cross References —** Appeals to chancery court and petition for writ in nature of mandamus or peremptory mandamus, see § 83-6-41.

## § 83-30-77. Severability.

If any provision of this chapter or the application of such provision to any circumstance is held invalid, the remainder of the chapter or the application of the provision to other circumstances, shall not be affected thereby.

**SOURCES: Laws, 2001, ch. 362, § 39, eff from and after July 1, 2001.**

# CHAPTER 31

## Mutual Companies

In General ........ 83-31-1
Mississippi Mutual Insurance Company Conversion, Reorganization and Merger Act ........ 83-31-101

## IN GENERAL

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### § 83-31-1. Formation.

Any number of persons not less than three (3), a majority of whom shall be bona fide residents of this state, by complying with the provisions of this chapter, may become, together with others who may hereafter be associated with them or their successors, a body corporate for the purpose of carrying on the business of mutual insurance as herein provided.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209a; 1930, § 5269; 1942, § 5783; Laws, 1918, ch. 157; Laws, 1997, ch. 410, § 14, eff from and after July 1, 1997.**

**Cross References —** Mutual insurance holding company exemption from certain provisions, see § 83-31-173.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 112.

**CJS.** 44 C.J.S., Insurance §§ 166, 167.

## § 83-31-3. Articles of association.

Any persons proposing to form any such company shall subscribe and acknowledge articles of association specifying:

(a) The name, the purpose for which formed, and the location of its principal or home office;

(b) The names and addresses of those composing the board of directors in which the management shall be vested until the first meeting of the members;

(c) The names and places of residence of the incorporators.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209b; 1930, § 5270; 1942, § 5784; Laws, 1918, ch. 157.**

**Cross References —** Organization of domestic insurance company, see §§ 83-19-1 et seq.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 115.

**CJS.** 44 C.J.S., Insurance § 169.

## § 83-31-5. Name must contain the word "mutual."

No name shall be adopted by such company which does not contain the word "mutual," or which is so similar to any name already in use by any such existing corporation, company, or association, organized or doing business in the United States, as to be confusing or misleading.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209c; 1930, § 5271; 1942, § 5785; Laws, 1918, ch. 157.**

RESEARCH REFERENCES

**CJS.** 44 C.J.S., Insurance § 167.

## § 83-31-7. Commissioner of Insurance to approve articles.

Such articles of association shall be submitted to the commissioner of insurance, herein designated "commissioner," and if prepared in accordance with this chapter, he shall approve and file the same in his office.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209d; 1930, § 5272; 1942, § 5786; Laws, 1918, ch. 157.**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 115.

**CJS.** 44 C.J.S., Insurance § 169.

## § 83-31-9. Corporate powers.

The company shall have legal existence from the approval and filing of such articles in the office of the commissioner. The board of directors named in such articles may thereupon adopt bylaws and proceed to transact the business of such company, provided that no insurance shall be put into force until the company has been licensed to transact insurance as provided by this chapter. The company shall have succession for the time limited in its articles of association; may determine the manner of calling and conducting the meetings and the mode of voting by proxy; may elect all necessary officers and prescribe the duties and tenure of officers; may sue and be sued and prosecute and be prosecuted to judgment and satisfaction before any court; may have a corporate seal; may contract and be contracted with within the limits of its corporate powers; may buy, hold and sell real estate and personal property; may borrow money and secure the payment of same by mortgage or otherwise.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209e; 1930, § 5273; 1942, § 5787; Laws, 1918, ch. 157; Laws, 1993, ch. 309, § 1, eff from and after passage (approved March 4, 1993).**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 112.

**CJS.** 44 C.J.S., Insurance § 172.

## § 83-31-10. Existence in perpetuity; extension of time of life to perpetuity.

(1) Whenever the period of existence of a mutual insurance company created with a life of fifty (50) years expires before March 4, 1993, then every such mutual company that continues to do business for ninety (90) days after March 4, 1993, by the doing of such business shall be deemed to have accepted an extension of the time of life of such mutual company to that of perpetuity. Such mutual company shall continue in existence as a de jure mutual company as fully and completely as if the articles of association had been thus amended before the end of the original fifty-year period. Likewise, whenever the period of existence of a mutual company created for a period of fifty (50) years expires hereafter, if such mutual company continues to do business thereafter for a period of ninety (90) days, the same shall operate as an acceptance of an extension of time of the life of such mutual company to that of perpetuity. Such mutual company shall continue in existence as a de jure mutual company as fully and completely as if the articles of association had been thus amended before the end of the original fifty-year period.

(2) When a mutual insurance company amends its articles of association in accordance with this section, it shall file within ninety (90) days thereafter in the Office of the Commissioner of Insurance a copy of the amended articles of association to show the extension of the time of life of such mutual company.

(3) This section shall in no way nullify any suit or claim accrued or to accrue before March 4, 1993.

**SOURCES: Laws, 1993, ch. 309, § 2, eff from and after passage (approved March 4, 1993).**

**Cross References —** Articles of association, see § 83-31-3.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 75, 76.

10 Am. Jur. Legal Forms 2d, Insurance, Form 149:22.

**CJS.** 44 C.J.S., Insurance § 167.

## § 83-31-11. Kind of insurance authorized.

Any company organized under the provisions of this chapter is empowered and authorized to make contracts of insurance or to reinsure or accept reinsurance, or any portion thereof, to the extent specified in its articles of association for the kinds of insurance following:

(a) **Fire insurance** — Against loss or damage to property and loss of use and occupancy by fire, lightning, hail, tempest, flood, earthquake, frost or snow, explosion, fire ensuing, and explosion, no fire ensuing, except explosion by steam boilers or flywheel; against loss or damage by water caused by the breakage or leakage of sprinklers, pumps, or other apparatus, water pipes, plumbing, or their fixtures, erected for extinguishing fires, and against accidental injury to such sprinklers, pumps, other apparatus, water pipes, plumbing, or fixtures; against the risks of inland transportation and navigation; upon automobiles, whether stationary or operated under their own power, against loss or damage by any of the causes or risks specified in this subsection, including also transportation, collision, liability, for damage to property resulting from owning, maintaining, or using automobiles, and including burglary and theft but not including loss or damage by risk of bodily injury to the person.

(b) **Liability insurance** — Against loss, expense, or liability by risk of bodily injury to death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or have assumed liability, including workman's compensation.

(c) **Disability insurance** — Against bodily injury or death by accident and disability by sickness.

(d) **Automobile insurance** — Against any or all loss, expense, and liability resulting from the ownership, maintenance, or use of any automobile or other vehicle, provided no policies shall be issued under this subsection against the hazard of fire alone.

(e) **Steam boiler insurance** — Against loss or liability to persons or property resulting from explosions or accidents to boilers, containers, pipes, engines, flywheels, elevators, and machinery in connection therewith, and against loss of use and occupancy caused thereby, and to make inspection and issue certificates of inspection thereon.

(f) **Use and occupancy insurance** — Against loss from interruption of trade or business which may be the result of any accident or casualty.

(g) **Life insurance** — To carry on the business commonly known as life insurance on the mutual plan, or disability insurance; to contract for the payment of endowments or annuities, or make and enter into such other contracts conditioned upon the continuance or cessation of human life.

(h) **Miscellaneous insurance** — Against loss or damage by any hazard upon any risk not provided for in this section, which is not prohibited by statute or at common law from being the subject of insurance.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209f; 1930, § 5274; 1942, § 5788; Laws, 1918, ch. 157; Laws, 1924, ch. 191.**

**Cross References —** Purposes for organization of insurance companies, see §§ 83-19-1, 83-19-3.

Capital required for various classes of companies, see § 83-19-31.

## RESEARCH REFERENCES

**Practice References.** Business Law Monographs, Volume IN1 — Business Uses of Life Insurance (Matthew Bender).

Business Law Monographs, Volume IN2 — Casualty and Liability Insurance (Matthew Bender).

**ALR.** Property insurance: construction and effect of provision excluding loss caused by earth movement or earthquake. 44 A.L.R.3d 1316.

Property insurance on aircraft; risks and losses covered. 48 A.L.R.3d 1120.

"Vehicle" or "land vehicle" within meaning of insurance policy provision defining risks covered or excepted. 65 A.L.R.3d 824.

Boiler and machinery insurance; risks and losses covered by policy or provision expressly covering boilers and machinery. 49 A.L.R.4th 336.

What is "flood" within exclusionary clause of property damage policy. 78 A.L.R.4th 817.

National Flood Insurance risks and coverage. 81 A.L.R. Fed. 416.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 117.

5 Am. Jur. Proof of Facts 3d, Negligent Failure to Install or Maintain Smoke Alarm or Sprinkler System, §§ 1 et seq.

**CJS.** 44 C.J.S., Insurance § 172.

## § 83-31-13. May reinsure certain risks.

(1) A mutual company transacting fire, casualty, or multiple line insurance business under the laws of this state, with the approval of the commissioner of insurance, may reinsure all risks undertaken by it in any company authorized to transact a similar class of insurance business in this state, and may transfer to the company assuming such risks all or such of its assets, reserves, liabilities, and obligations of every character as the agreement approved by the commissioner shall provide.

(2) This section shall not prevent such a company from reinsuring any risks or fractional parts thereof, not situated in this state, in any company licensed by the state in which such risks are located.

**SOURCES: Codes, 1942, § 5788.5; Laws, 1960, ch. 373, §§ 1-3.**

### RESEARCH REFERENCES

**Am Jur.** 44A Am. Jur. 2d, Insurance §§ 1842 et seq.

**CJS.** 46 C.J.S., Insurance §§ 1720 et seq.

## § 83-31-15. Fraternal societies may be converted.

Any fraternal benefit society organized under the laws of this state may be converted into a mutual life or mutual life and disability insurance company, so as to come within the provisions of all laws governing mutual companies and operate under this chapter upon the terms and conditions as follows:

Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular mutual life or disability insurance company shall be to the best interests of the society and its members, or whenever a majority of the members in good standing of any such domestic fraternal benefit society shall, in writing, signify their desire for such conversion, then, in either event, said fraternal benefit society may adopt and file with the insurance commissioner of Mississippi an amendment to its articles of incorporation, authorizing it to be converted from a fraternal to a domestic mutual life or disability insurance company; and said amendment shall become operative upon its approval by and filing with the insurance commissioner, unless a later time be provided in said amendment. If the amendment is approved by the insurance commissioner, he shall issue his certificate of approval in writing. Thereafter the company shall have legal existence as a domestic mutual life or disability insurance company, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and be subject to all of the terms and provisions of this chapter governing mutual companies.

Provided, however, that no such conversion from a fraternal benefit society to a regular mutual life or disability insurance company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to each member of such fraternal benefit society at his last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by said supreme governing body; but the notice provided herein shall not apply to or be required of any fraternal benefit society whose district councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into said mutual life and disability company before April 10, 1924.

**SOURCES: Codes, 1930, § 5275; 1942, § 5789; Laws, 1924, ch. 191.**

**Cross References —** Conversion of fraternal societies into stock companies, see § 83-29-71.

Conversion of fraternal benefit societies into stock companies, see § 83-29-71.

Conversion of larger fraternal benefit society into mutual or stock insurer, see § 83-30-29.

### JUDICIAL DECISIONS

**1. In general.**

The conversion of a fraternal society into a mutual life and disability company destroys the immunity provided by Code 1930, § 5235 [Code 1942, § 5749]; and consequently, a mutual insurance company, ceasing to be a fraternal society, was bound by the acts of its agents in misleading an insured as to the extent of disability necessary to entitle him to file a claim therefor. Columbian Mut. Life Ins. Co. v. Gipson, 185 Miss. 890, 189 So. 799 (1939).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 117.

**CJS.** 44 C.J.S., Insurance § 168.

## § 83-31-17. Principal office.

Any mutual life insurance company may acquire, own, or maintain a principal office, by and with the written consent of the insurance commissioner, in any state in which said company is admitted to do business, and may provide that the meetings of its board of directors or governing body may be held at said principal office. All business transacted at said principal office shall be as valid in all respects as if the meetings of the board of directors or governing body were held in this state.

**SOURCES: Codes, 1930, § 5276; 1942, 5790; Laws, 1924, ch. 191.**

**Cross References —** Meeting of governing body of fraternal societies outside state, see § 83-29-33.

### RESEARCH REFERENCES

**CJS.** 44 C.J.S., Insurance § 167.

## § 83-31-19. Certain companies not affected.

The provisions of this chapter shall not apply to foreign mutual reserve insurance companies doing business in this state upon the legal reserve plan.

**SOURCES: Codes, 1930, § 5277; 1942, § 5791; Laws, 1924, ch. 191.**

**Cross References —** Admission of foreign mutual companies, see § 83-31-39.

## § 83-31-21. License.

No such company shall issue policies or transact any business of insurance unless it shall hold a license from the commissioner authorizing the transaction of such business. Such license shall not be issued until and unless the company shall have in paid-up or contributed surplus the amount required in Section 83-19-73.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209g; 1930, § 5278; 1942, § 5792; Laws, 1918, ch. 157; Laws, 1956, ch. 336, § 2; Laws, 1997, ch. 410, § 16, eff from and after July 1, 1997.**

**Editor's Note —** Section 83-19-73 referred to in this section was repealed by Laws, 1998, ch. 323, § 9, eff from and after July 1, 1998. For similar provisions, see § 83-19-31.

**Cross References —** Capital and surplus requirements, see § 83-19-31.

## § 83-31-23. Corporations and associations may hold policies.

Any public or private corporation, board, or association in this state or elsewhere may make application, enter into agreements for, and hold policies in any such mutual insurance company. Any officer, stockholder, trustee, or legal representative of any such corporation, board, association, or estate may be recognized as acting for or on its behalf for the purpose of such membership; but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any such mutual insurance company is hereby declared to be incidental to the purpose for which such corporation is organized, and as much granted as the rights and powers expressly conferred.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209h; 1930, § 5279; 1942, § 5793; Laws, 1918, ch. 157.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 122.

**CJS.** 44 C.J.S., Insurance § 170.

## § 83-31-25. Voting of members.

Every member of the company shall be entitled to one vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209i; 1930, § 5280; 1942, § 5794; Laws, 1918, ch. 157.**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 123.

**CJS.** 44 C.J.S., Insurance § 170.

## § 83-31-27. Premiums.

The maximum premium payable by any member shall be expressed in the policy or in the application for the insurance. Such maximum premium may be a cash premium and an additional contingent premium not less than the cash premium, or may be solely a cash premium. No policy shall be issued for a cash premium without an additional contingent premium unless the company has a surplus which is not less in amount than the capital stock required of domestic stock insurance companies transacting the same kind of insurance.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209j; 1930, § 5281; 1942, § 5795; Laws, 1918, ch. 157.**

**Cross References** — Capital required for various classes of companies, see § 83-19-31.

RESEARCH REFERENCES

**CJS.** 44 C.J.S., Insurance §§ 550 et seq.

## § 83-31-29. Investment of assets.

No such company shall invest any of its assets except in accordance with the laws of this state relating to the investment of the assets of domestic stock companies transacting the same kind of insurance.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209k; 1930, § 5282; 1942, § 5796; Laws, 1918, ch. 157.**

**Cross References** — Authorized investment of funds by domestic insurance companies, see § 83-19-51.

Authorized investment of funds by fraternal societies, see § 83-29-17.

Approved investments for assets of larger fraternal benefit societies, see § 83-30-41.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 118.

**CJS.** 44 C.J.S., Insurance § 173.

## § 83-31-31. Reserves and unearned premiums.

Such company shall maintain unearned premium and other reserves separately for each kind of insurance, upon the same basis as that required of domestic stock insurance companies transacting the same kind of insurance; provided, that any reserve for losses or claims based upon the premium income shall be computed upon the net premium after deducting any so-called dividend or premium returned or credited to the member.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209l; 1930, § 5283; 1942, § 5797; Laws, 1918, ch. 157.**

**Cross References** — Reserves required of insurance companies, see § 83-5-23.
Computation of reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 71.

**CJS.** 44 C.J.S., Insurance §§ 174, 175.

## § 83-31-33. Deficiency in assets.

Such company not possessed of assets at least equal to the unearned premium reserve and other liabilities shall make an assessment upon its members liable to assessment to provide for such deficiency, such assessment to be against each such member in proportion to such liability as expressed in his policy. The commissioner may, by written order, relieve the company from an assessment or other proceedings to restore such assets during the time fixed in such order.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209m; 1930, § 5284; 1942, § 5798; Laws, 1918, ch. 157.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 118.

**CJS.** 44 C.J.S., Insurance § 173.

## § 83-31-35. Money advanced by officers or members.

Any director, officer, or member of any such company, or any other person, may advance to such company any sum or sums of money necessary for the purpose of its business or to enable it to comply with any of the requirements of the law. Such moneys and such interest thereon as may have been agreed upon, not exceeding ten percent (10%) per annum, shall not be a liability or claim against the company or any of its assets, except as herein provided, and shall be repaid only out of the surplus earnings of such company. No commission nor promotion expenses shall be paid in connection with the advance of any such money to the company, and the amount of such advance shall be reported in each annual statement.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209n; 1930, § 5285; 1942, § 5799; Laws, 1918, ch. 157.**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 142, 143 et seq.

**CJS.** 44 C.J.S., Insurance § 176.

## § 83-31-37. Delivery of policies through licensed agents.

Such mutual company shall comply with the provisions of any law applicable to any stock insurance companies effecting the same kind of insurance requiring that policies be countersigned and delivered through a licensed agent. This requirement shall not apply to any policy of such mutual company on which no commission shall be paid to any local agent. Such mutual company may insert, in any form of policy prescribed by the law of this state, such provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with any law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law, and a copy of such policy and endorsement, if any, shall have been first filed with and shall not have been disapproved by the commissioner.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209o; 1930, § 5286; 1942, § 5800; Laws, 1918, ch. 157; Laws, 2001, ch. 510, § 33, eff from and after January 1, 2002.**

**Cross References —** Licensing of insurance agents, see § 83-17-5.

Prohibition against paying commission to unauthorized agent, see § 83-17-7.

Requirement that insurance policies be written by resident local agents, see § 83-17-21.

RESEARCH REFERENCES

**ALR.** Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

**CJS.** 44 C.J.S., Insurance § 392.

## § 83-31-39. Admission of foreign mutual companies.

Any mutual insurance company organized outside of this state and authorized to transact the business of insurance on the mutual plan in any state, district, or territory, except foreign mutual life insurance companies doing business upon the legal reserve plan, shall be admitted and licensed to transact the kinds of insurance authorized by its charter or articles of association to the extent and with the powers and privileges specified in this chapter when it shall be solvent under this chapter and shall have complied with the following requirements:

(a) Filed with the commissioner a certified copy of its charter or articles of association;

(b) Filed with the commissioner a copy of its bylaws certified to by its secretary;

(c) Appointed the commissioner its agent for the service of process in any action, suit, or proceedings in any court of this state, which authority shall continue as long as any liability shall remain outstanding in this state;

(d) Filed a financial statement under oath, in such form as the commissioner may require, and have complied with other provisions of law applicable to the filing of papers and furnishing information by stock companies on application for authority to transact the same kind of insurance.

(e) If organized without the United States, make and maintain the deposit required of stock insurance companies formed without the United States transacting the same kind of insurance. Upon compliance by any such foreign company with the provisions in this section, such company shall be licensed and authorized to transact business in this state, subject to all the provisions of law relating to information to and examinations by the commissioner, annual reports, taxes, and the renewal of license applicable to stock insurance companies transacting the same kind of insurance, except as otherwise provided in this chapter.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209p; 1930, § 5287; 1942, § 5801; Laws, 1918, ch. 157.**

**Cross References —** Requirements for admission of foreign insurance companies generally, see §§ 83-21-1, 83-21-3.

Laws applicable to foreign insurance companies, see § 83-21-7.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 85.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 22 (petition or application for writ of mandamus to compel issuance of license to foreign corporation to conduct insurance business within state).

**CJS.** 44 C.J.S., Insurance §§ 129, 130.

## § 83-31-41. Annual reports.

Every such mutual insurance company shall make its annual report in such form and submit to such examinations as may be required by the commissioner of insurance. As far as practicable, such examinations of foreign mutual insurance companies shall be made in co-operation with the insurance departments of other states, and the forms of annual report shall be such as are in general use throughout the United States.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209q; 1930, § 5288; 1942, § 5802; Laws, 1918, ch. 157.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance § 128.

## § 83-31-43. Applicability of other laws.

(1) Except as expressly exempted by this chapter, all mutual companies organized or admitted to do business in this state shall be subject to any and all other laws of this state governing insurance companies.

(2) All laws enacted whereby the Commissioner of Insurance of the State of Mississippi is granted general authority as to reports, audits, regulations, supervisions, reorganizations or liquidations shall be applicable to all public and private corporations, boards or associations organized under the provisions of this title and chapter regardless of any provisions of law or statute to the contrary.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209r; 1930, § 5289; 1942, § 5803; Laws, 1918, ch. 157; Laws, 1994, ch. 422, § 3, eff from and after July 1, 1994.**

### JUDICIAL DECISIONS

**1. In general.**

Where statute provided that mutual insurance company should pay premium tax in lieu of all licenses and taxes except ad valorem taxes on realty, mutual company held not liable for privilege tax authorized by general statute. Gulley v. Lumbermen's Mut. Cas. Co., 176 Miss. 388, 166 So. 541 (1936), error overruled, 176 Miss. 404, 168 So. 609 (1936).

Statute relating to collection of privilege and premium taxes from insurance companies, providing that section [Code 1942, § 5803] covering premium taxes should apply to mutual insurance companies, held to authorize collection of privilege tax from mutual company, notwithstanding prior statute providing for payment of premium tax by mutual companies in lieu of other taxes. Gulley v. Lumbermen's Mut. Cas. Co., 176 Miss. 388, 166 So. 541 (1936), error overruled, 176 Miss. 404, 168 So. 609 (1936).

## § 83-31-45. Taxation of premium receipts.

(1) The taxable premium or premium receipts of any mutual insurance company organized or admitted in this state under this chapter for the purpose of taxation under any law of this state shall be the gross premiums received for direct insurance upon property or risks in this state, deducting premiums upon policies not taken and premiums returned on cancelled policies and also any refund or return made to the policyholder other than for loss. Such mutual insurance companies shall pay into the State Treasury through the State Tax Commission a premium tax in accordance with the provisions of Section 27-15-103 et seq.

(2) In the event that the Mississippi Supreme Court or another court finally adjudicates that any tax levied prior to July 1, 1985, under the provisions of this section was collected unconstitutionally and that a liability for a credit or refund for such collection has accrued, then the rate of tax set

forth above shall be increased to four percent (4%) for a period of six (6) years beginning July 1 following such adjudication.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209s; 1930, § 5290; 1942, § 5804; Laws, 1918, ch. 157; Laws, 1978, ch. 441, § 5; Laws, 1982, ch. 351, § 17; Laws, 1983, ch 452, § 1; Laws, 1985, ch. 530, § 4; Laws, 1997, ch. 324, § 4, eff from and after July 1, 1997.**

**Editor's Note** — Section 20 of ch. 351, Laws of 1982, effective July 1, 1982, provides as follows:

"SECTION 20. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under any section contained herein prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective, or shall thereafter be begun; and the provisions of any section contained herein are expressly continued in full force, effect and operation for the purpose of the assessment and collection of any taxes due or accrued thereunder prior to the date on which this act becomes effective, or the filing of reports, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 2 of ch. 452, Laws of 1983, effective from and after April 1, 1983, provides as follows:

"SECTION 2. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under the insurance premium tax laws prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective or shall thereafter be begun; and the provisions of the insurance premium tax laws are expressly continued in full force, effect and operation for the purpose of the assessment, collection and enrollment of liens for any taxes due or accrued and executing of any warrant under said laws prior to the date on which this act becomes effective, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

**Cross References** — Premium tax, see §§ 27-15-103 et seq.

Reduction in premium tax for insurers who make qualifying Mississippi investments, see § 27-15-129.

Credit for overpayment of taxes, see § 27-15-131.

Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

## JUDICIAL DECISIONS

**1. In general.**

Appellee, a domestic mutual insurance company, is taxable under Code 1930, § 5290 [Code 1942, § 5809].The contention that section 107, ch. 20, Gen. Loc. and Priv. Laws 1935, establishes a different rule is not well taken, because section 106 of that chapter expressly excepts and takes out of said chapter 20 domestic insurance companies taxed as otherwise provided by law. Williams v. North Am. Mut. Ins. Co., 172 So. 334 (Miss. 1937).

Where statute provided that mutual insurance company should pay premium tax in lieu of all licenses and taxes except ad valorem taxes on realty, mutual company held not liable for privilege tax authorized by general statute. Gulley v. Lumbermen's

Mut. Cas. Co., 176 Miss. 388, 166 So. 541 (1936), error overruled, 176 Miss. 404, 168 So. 609 (1936).

Statute relating to collection of privilege and premium taxes from insurance companies, providing that section [Code 1942, § 5804] covering premium taxes should apply to mutual insurance companies, held to authorize collection of privilege tax from mutual company, notwithstanding prior statute providing for payment of premium tax by mutual companies in lieu of other taxes. Gulley v. Lumbermen's Mut. Cas. Co., 176 Miss. 388, 166 So. 541 (1936), error overruled, 176 Miss. 404, 168 So. 609 (1936).

## RESEARCH REFERENCES

**Am Jur.** 71 Am. Jur. 2d, State and Local Taxation §§ 368 et seq.

**CJS.** 44 C.J.S., Insurance §§ 118-120, 131, 132.

## § 83-31-47. Merger with foreign mutual insurance company.

(1) A domestic mutual insurance company may effect a merger with one or more domestic mutual insurance companies, or with one or more foreign mutual insurance companies, if such merger is authorized by the laws of the state under which each such foreign company is organized.

(2) The Commissioner of Insurance shall review and approve the plan to merge the mutual insurance companies before submission of the plan to the eligible members for their consideration and vote. The plan must be approved by two-thirds (⅔) of those eligible members who vote in person or by proxy at a duly called eligible members' meeting to consider the plan of merger. The commissioner may require mutual companies to comply with appropriate requirements as that analogous to those of a stock company merger under Sections 83-6-24 and 83-19-99.

**SOURCES: Laws, 1998, ch. 576, § 41, eff from and after July 1, 1998.**

**Cross References —** Good faith failure to provide notice, see § 83-31-135.

Applicability of requirements of this section to merger or consolidation of mutual insurance holding company, see § 83-31-157.

Mutual insurance holding company investments, see § 83-31-167.

## MISSISSIPPI MUTUAL INSURANCE COMPANY CONVERSION, REORGANIZATION AND MERGER ACT

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## § 83-31-101. Short title.

The provisions of Sections 83-31-101 through 83-31-181 may be cited as the "Mississippi Mutual Insurance Company Conversion, Reorganization and Merger Act."

**SOURCES: Laws, 1998, ch. 576, § 1, eff from and after July 1, 1998.**

**Cross References** — Domestic mutual insurance company merger with foreign mutual insurance company, see § 83-31-47.

Mutual insurance holding company provisions, see § 83-31-145 et seq.

Mutual insurance holding company conversion to stock holding company, see § 83-31-177.

## § 83-31-103. Definitions.

As used in Sections 83-31-101 through 83-31-143, the following terms shall have the meaning ascribed herein unless the context indicates otherwise:

(a) "Conversion plan" means a plan adopted under Sections 83-31-101 through 83-31-143 by the board of directors of a domestic mutual insurance company to convert the mutual insurance company into a stock company.

(b) "Converted stock company" means a domestic stock insurance company that has converted under Sections 83-31-101 through 83-31-143 from a domestic mutual insurance company.

(c) "Eligible member" means a member of a mutual insurance company whose policy is in force on the date that the mutual insurance company's board of directors adopts a conversion plan. The term does not include a person whose policy becomes effective after the date that the board of directors adopts the conversion plan but before the conversion plan's effective date.

(d) "Mutual insurance company" means a domestic mutual insurance company formed under Section 83-31-1 et seq. except for domestic mutual insurance companies that have active life insurance or annuities products in force.

(e) "Participating policy" means a policy that grants a holder the right to receive dividends or other distributions if, as and when, declared by the mutual insurance company that issued such policy.

(f) "Stock company" means a domestic stock insurance company subject to Section 83-19-1 et seq.

**SOURCES: Laws, 1998, ch. 576, § 2, eff from and after July 1, 1998.**

## § 83-31-105. Conversion plan adoption and approval.

(1) A mutual insurance company that seeks to convert to a stock company must adopt, by the affirmative vote of not less than two-thirds (⅔) of the members of its board of directors, a conversion plan consistent with the requirements of Sections 83-31-101 through 83-31-143. A mutual insurance company may not engage in the business of insurance as a stock company until it complies with the requirements of Sections 83-31-101 through 83-31-143.

(2) Before the eligible members of a mutual insurance company may vote on approval of a conversion plan, the mutual insurance company must comply with Section 83-31-107 and other applicable requirements under Sections 83-31-101 through 83-31-143.

**SOURCES: Laws, 1998, ch. 576, § 3, eff from and after July 1, 1998.**

**Cross References** — Alternative conversion plans, see § 83-31-127.

## § 83-31-107. Commissioner approval of conversion plan; public hearings.

(1) Not later than the ninetieth day after the date on which a mutual insurance company's board of directors adopts a conversion plan, the company shall file with the commissioner:

(a) A copy of the conversion plan, including the documents relating to the conversion plan;

(b) The independent evaluation of a pro forma market value required by Section 83-31-121(2);

(c) The form of notice required by Section 83-31-111;

(d) The form of proxy to be solicited from eligible members under Section 83-31-113(2);

(e) The form of notice required by Section 83-31-129(3) to persons whose policies are issued after adoption of the conversion plan but before the effective date of the conversion plan;

(f) An audited financial statement prepared on a statutory basis in accordance with the insurance laws of the State of Mississippi, including an actuarial opinion for the most recent calendar year ended, or a copy thereof, if the statement was previously filed with the commissioner;

(g) The proposed amended or restated articles of association of the converted stock company, which shall include a change of the name of the company to delete the word "mutual" from the name of such company and proposed amended or restated bylaws of such company;

(h) A statement regarding acquisition of control, if applicable, as required by Section 83-6-1 et seq.; and

(i) Any other information as required under rules or regulations or as requested by the commissioner.

(2) Except as otherwise provided by this subsection, the commissioner shall approve or disapprove a conversion plan not later than the ninetieth day after the first day on which all the documents and other information required under subsection (1) of this section are filed with the commissioner. The commissioner may not extend the time for approval or disapproval beyond the ninety-day time period unless he finds it necessary to retain a qualified expert in accordance with subsection (4) of this section, in which case he may extend the time for review for an additional sixty (60) days beyond the initial ninety-day period. Notwithstanding the stated time limits herein, the commissioner may extend the time for approval or disapproval for an additional thirty (30) days beyond the date on which any amendment to such plan is filed with the commissioner. The commissioner shall, within five (5) days of approving or disapproving a conversion plan, give written notice to the mutual insurance company of the commissioner's decision and, in the event of disapproval, a detailed statement of the reasons for the adverse decision. If a plan is disapproved, then the conversion plan may be amended and resubmitted to the commissioner for his approval or disapproval as provided in Sections 83-31-101 through 83-31-143. If the commissioner disapproves the plan, then the mutual

insurance company may appeal the commissioner's decision as provided by the laws of this state to the Chancery Court of the First Judicial District of Hinds County, Mississippi.

(3) The commissioner shall approve a conversion plan if the commissioner finds that the conversion plan complies with Sections 83-31-101 through 83-31-143, the conversion plan's method of allocating subscription rights or other value is fair and equitable and the conversion plan is otherwise fair and equitable to members and policyholders, and the converted stock company would satisfy the requirements applicable to a domestic stock company; however, the commissioner may not approve such a conversion plan and shall disapprove such a plan if the commissioner finds that (a) the effect of the conversion plan would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein; (b) the financial condition of any party to the conversion plan is such as might jeopardize the financial stability of the insurers which are parties to the plan or prejudice the interests of their policyholders; (c) the conversion plan or the plans for operation of the parties to the conversion plan following implementation of the conversion plan are not in the public interest; (d) the competence, experience and integrity of those persons who would control the operations of the parties to the conversion plan are such that it would not be in the interest of policyholders of the parties to the conversion plan or of the public to permit the conversion plan; (e) the conversion plan's method of allocating subscription rights or other value is not fair and equitable; (f) the conversion plan is not fair and equitable to the members and policyholders; (g) implementation of the conversion plan is likely to be hazardous or prejudicial to the insurance buying public; or (h) the conversion unfairly enriches the officers and directors of the converting insurer.

(4) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist the commissioner in reviewing the conversion plan and the independent evaluation of the pro forma market value required under Section 83-31-121(2).

(5) The commissioner may hold a public hearing to allow comment on the conversion plan after giving written notice to the mutual insurance company and other interested persons, all of whom have the right to appear at the hearing. Notice to interested persons who have not filed an appearance in the matter may be made in any reasonable manner deemed appropriate by the commissioner with the costs thereof assessed to the mutual insurance company.

**SOURCES: Laws, 1998, ch. 576, § 4, eff from and after July 1, 1998.**

**Cross References —** Requirements for conversion plan to take effect, see § 83-31-129.

## § 83-31-109. Notice to eligible members and comments; amendment and termination of plan.

(1) The conversion plan may be:

(a) Amended by a vote of two-thirds (⅔) of the members of the board of directors of the applicant in response to the comments or recommendations of the commissioner or any other state or federal agency or governmental entity before any solicitation of proxies from members of the mutual insurance company to vote on the conversion plan or at any time with the consent of the commissioner, except that any material amendment after the members' approval shall require the members' approval; or

(b) Terminated by a vote of two-thirds (⅔) of the members of the board of directors of the applicant at any time before members of the mutual insurance company vote on the conversion plan and, otherwise, at any time with the consent of the commissioner.

(2)(a) Within twenty (20) business days after filing with the commissioner the documents required under Section 83-31-107(1), the mutual insurance company shall send to each eligible member a notice advising the eligible member of the adoption and filing of the conversion plan and of the member's right to provide to the commissioner and the mutual insurance company comments on the plan.

(b) As an alternative to the notice required under paragraph (a) of this subsection, the mutual insurance company may use any other means which is reasonably designed to provide notice to eligible members and which alternative means of providing notice is approved by the commissioner.

(c) The notice required under paragraphs (a) or (b) of this subsection shall include a description of the procedure to be used in making comments.

(3) An eligible member who elects to make comments must make the comments in writing (a) if notice is sent to each eligible member, not later than the thirtieth day after the date on which the notice is sent; or (b) if an alternative means of providing notice is approved by the commissioner, not later than such date for receipt of comments approved by the commissioner.

**SOURCES: Laws, 1998, ch. 576, § 5, eff from and after July 1, 1998.**

**Cross References** — Good faith failure to provide notice required by this section, see § 83-31-135.

## § 83-31-111. Member meeting notice for voting on conversion plan.

(1) Within sixty (60) days after the commissioner's approval of the plan, the mutual insurance company shall send to each eligible member notice of the members' meeting to vote on the conversion plan. The notice must be sent to the member's last known address, as shown on the mutual insurance company's records, before the thirtieth day preceding the date set for the meeting. The notice shall:

(a) Briefly but fairly describe the material terms and provisions of the proposed conversion plan; and

(b) Inform the member of the member's right to vote on the conversion plan.

(2) If the meeting to vote on the conversion plan is held during the mutual insurance company's annual meeting of policyholders, only a combined meeting notice is required.

**SOURCES: Laws, 1998, ch. 576, § 6, eff from and after July 1, 1998.**

**Cross References** — Good faith failure to provide notice required by this section, see § 83-31-135.

## § 83-31-113. Member votes on plan and amending or restating articles of association.

(1) A conversion plan is adopted on receiving the affirmative vote of at least two-thirds (⅔) of the votes cast in person or by proxy by eligible members at a duly convened meeting to consider the plan of conversion.

(2) Members entitled to vote on the proposed conversion plan may vote in person or by proxy. The number of votes each eligible member may cast shall be determined by the mutual insurance company's bylaws. If the bylaws are silent, each eligible member may cast one (1) vote.

(3) At the meeting held to vote on the conversion plan, the members shall also consider the adoption of amended or restated articles of association. Adoption of the amended or restated articles requires the affirmative vote of at least two-thirds (⅔) of the votes cast in person or by proxy by eligible members.

**SOURCES: Laws, 1998, ch. 576, § 7, eff from and after July 1, 1998.**

## § 83-31-115. Filing minutes concerning member plan adoption meeting.

Not later than the thirtieth day after the date on which the eligible members adopt the conversion plan at a duly convened meeting, the converted stock company shall file with the commissioner the minutes of the meeting of the eligible members at which the conversion plan was adopted.

**SOURCES: Laws, 1998, ch. 576, § 8, eff from and after July 1, 1998.**

## § 83-31-117. Conversion plan requirements; effect on existing policies; nonparticipating policies.

(1) Each conversion plan must include the provisions required by Sections 83-31-101 through 83-31-143 and by any rules or regulations adopted by the commissioner.

(2) Each policy in effect on the effective date of the conversion remains in effect under the terms of that policy, except that the following rights, to the

extent they existed in the mutual insurance company, are extinguished on the effective date of the conversion:

(a) Any voting rights of policyholders provided under the policy;

(b) Except as provided in subsection (3) of this section, a right to share in the surplus or profits of the mutual insurance company; and

(c) Any assessment provisions provided under the policy.

(3) Except as otherwise provided by Section 83-31-143, the holder of a participating policy in effect on the date of the conversion continues to have a right to receive dividends or distributions as provided by the participating policy.

(4) Except for the mutual insurance company's guaranteed renewable accident and health policies and guaranteed renewable, noncancellable accident and health policies, on the renewal date of a participating policy, the converted stock company may issue the insured a nonparticipating policy as a substitute for the participating policy on such terms and conditions and on such policy forms as shall be approved by the commissioner.

**SOURCES: Laws, 1998, ch. 576, § 9, eff from and after July 1, 1998.**

## § 83-31-119. Subscription rights and alternatives.

(1) Except for an alternative plan under Section 83-31-127, each conversion plan must specify the subscription rights of eligible members.

(2) The plan must include a provision that:

(a) Each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of the converted stock company, including a method for determining the number of shares which may be purchased; and

(b) In the aggregate, all eligible members have the right, before the right of any other party, to purchase one hundred percent (100%) of the capital stock of the converted stock company; however, that such plan may provide for the sale or distribution of capital stock to the holders of surplus notes, if any, but only upon such terms and conditions as may be approved by the commissioner.

(3) As an alternative to subscription rights in the converted stock company, the conversion plan may provide that each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of one of the following:

(a) A corporation organized for the purpose of purchasing and holding all the stock of the converted stock company;

(b) A stock insurance company owned by the mutual insurance company into which the mutual insurance company is to be merged; or

(c) An unaffiliated stock insurance company or other corporation that is to purchase all the stock of the converted stock company.

(4) The conversion plan must provide that the subscription rights are allocated in whole shares among the eligible members using a fair and equitable method, with such exceptions and other terms and conditions as the

commissioner may approve. The method may consider, but is not required to consider, how the different classes of policies of the eligible members contributed to the surplus of the mutual insurance company or any other factors that may be fair or equitable as determined by the board of directors.

(5) The conversion plan must provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights under this section.

(6) Notwithstanding any other provision of Sections 83-31-47 or 83-31-101 through 83-31-181 to the contrary, no officer, director or employee of any insurer reorganizing under any provision of Sections 83-31-47 or 83-31-101 through 83-31-181 shall be eligible to receive subscription rights to, purchase or acquire any stock in the reorganized stock insurance company under any plan except in accordance with his rights as an eligible member, and then he shall receive only such rights as are received by other similarly situated eligible members.

**SOURCES: Laws, 1998, ch. 576, § 10, eff from and after July 1, 1998.**

## § 83-31-121. Capital stock sales and restrictions.

(1) The conversion plan must provide that any shares of capital stock not sold or distributed to holders of surplus notes, or subscribed to by eligible members exercising subscription rights under Section 83-31-119, may be sold in a private placement, public offering or other alternative method approved by the commissioner.

(2) The conversion plan must set the total price of the capital stock in an amount equal to the estimated pro forma market value of the converted stock company based on an independent valuation by a qualified expert, giving consideration to the amount of capital deemed necessary by the board of directors to be raised by the company. The pro forma market value may be the value estimated to be necessary to attract full subscription for the shares, as indicated by the independent valuation, and may be stated as a range of values.

(3) The conversion plan shall set the purchase price per share of capital stock at any reasonable amount approved by the commissioner. The purchase price per share need not be the same for each class of purchaser; however, eligible members purchasing stock in accordance with subscription rights received under Section 83-31-119 shall have the right to purchase shares at the lowest available purchase price under the plan.

(4) The conversion plan must provide that a person or group of persons acting in concert may not acquire, in the public offering or private placement or through the exercise of subscription rights, more than ten percent (10%) of the capital stock of the converted stock company except with the approval of the commissioner. This limitation does not apply to an entity that purchases one hundred percent (100%) of the capital stock of the converted company as part of the conversion plan approved by the commissioner.

**SOURCES: Laws, 1998, ch. 576, § 11, eff from and after July 1, 1998.**

### § 83-31-125. Liquidation account to be created.

The conversion plan may provide for the creation of a liquidation account for the benefit of members in the event of voluntary liquidation after conversion in an amount equal to the surplus of the mutual insurance company, exclusive of the principal amount of any surplus note, on the last day of the quarter immediately preceding the date of adoption of the conversion plan.

**SOURCES: Laws, 1998, ch. 576, § 12, eff from and after July 1, 1998.**

### § 83-31-127. Alternative conversion plans that do not rely on nontransferable subscription rights.

(1) The board of directors may adopt a conversion plan that does not rely wholly or partially on issuing nontransferable subscription rights to members to purchase stock of the converted stock company if the commissioner finds that the alternative conversion plan complies with Section 83-31-107(3).

(2) An alternative conversion plan may:

(a) Include the merger of a domestic mutual insurance company into a domestic or foreign stock insurance company;

(b) Provide for issuing stock, cash, or other consideration to members instead of subscription rights;

(c) Provide for the formation of a mutual holding company under Section 83-31-145 et seq.; or

(d) Set forth another plan containing any other provisions approved by the commissioner.

(3) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist in reviewing whether the alternative conversion plan may be approved by the commissioner.

**SOURCES: Laws, 1998, ch. 576, § 13, eff from and after July 1, 1998.**

### § 83-31-129. Requirements for conversion plan to take effect; member rights.

(1) For a conversion plan to take effect:

(a) The commissioner must approve the conversion plan; and

(b) The eligible members must approve the conversion plan and adopt the amended or restated articles of association.

(2) A conversion plan takes effect when the amended or restated articles of association are filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the amended or restated articles of association as filed.

(3)(a) On issuance of a policy after a conversion plan has been adopted by the board of directors but before the effective date of the conversion plan, the mutual insurance company shall send to the member to whom the policy is issued a written notice regarding the conversion plan.

(b) Except as provided by paragraph (d) of this subsection, a member of an accident and health insurance company entitled to receive the notice described by paragraph (a) of this subsection is entitled to rescind the member's policy and receive a full refund of any amount paid for the policy not later than the ten (10) days after the date on which the member receives the notice.

(c) Except as provided by paragraph (d) of this subsection, each member who is insured under a property or casualty insurance policy is entitled to receive the notice provided by paragraph (a) of this subsection and shall be advised of the member's right to cancel the policy and receive a pro rata refund of unearned premiums.

(d) A member who has made or filed a claim under the insurance policy is not entitled to a right to receive a refund under paragraph (b) or (c) of this subsection. A person who has exercised the rights provided by paragraph (b) or (c) of this subsection is not entitled to make or file a claim under the insurance policy.

**SOURCES: Laws, 1998, ch. 576, § 14, eff from and after July 1, 1998.**

## § 83-31-131. Results on plan effective date.

(1) On the effective date of the conversion:

(a) The corporate existence of the mutual insurance company continues in the converted stock company; and

(b) All assets, rights, franchises and interests of the mutual insurance company in and to property, real, personal or mixed, and any accompanying things in action, are vested in the converted stock company, without a deed or transfer, and the converted stock company assumes all the obligations and liabilities of the mutual insurance company.

(2) Unless otherwise specified in the conversion plan, the directors and officers of the mutual insurance company serving on the effective date of the conversion serve as directors and officers of the converted stock company until new directors and officers of the converted stock company are elected under the articles of association and bylaws of the converted stock company.

**SOURCES: Laws, 1998, ch. 576, § 15, eff from and after July 1, 1998.**

## § 83-31-133. Fees, costs and expenses.

(1) A director, officer, agent or employee of the mutual insurance company may not receive a fee, commission or other consideration, other than that person's usual salary or compensation, for aiding, promoting or assisting in a conversion under Sections 83-31-101 through 83-31-143, except as provided by the conversion plan approved by the commissioner.

(2) All the costs and expenses connected with a conversion plan shall be paid for or reimbursed by the mutual insurance company or the converted stock company.

**SOURCES: Laws, 1998, ch. 576, § 16, eff from and after July 1, 1998.**

## § 83-31-135. Good faith failure to provide notice.

If the mutual insurance company complies substantially and in good faith with the notice requirements of Sections 83-31-47 or 83-31-101 through 83-31-181, the mutual insurance company's failure to send a member the required notice under Section 83-31-109(2)(a) or Section 83-31-111(1) does not impair the validity of any action taken under Sections 83-31-47 or 83-31-101 through 83-31-181.

**SOURCES: Laws, 1998, ch. 576, § 17, eff from and after July 1, 1998.**

## § 83-31-137. Actions challenging validity.

An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a conversion plan under Sections 83-31-101 through 83-31-143 must begin in the Chancery Court of the First Judicial District of Hinds County, Mississippi, not later than the thirtieth day after the effective date of the conversion plan.

**SOURCES: Laws, 1998, ch. 576, § 18, eff from and after July 1, 1998.**

## § 83-31-139. Insolvent companies or companies in financially hazardous condition; waiver.

(1) If a mutual insurance company is insolvent or, in the judgment of the commissioner, is in hazardous financial condition, its board of directors, by a majority vote, may petition the commissioner to waive the provisions of Sections 83-31-101 through 83-31-143 requiring notice to and policyholder approval of the planned conversion.

(2) The petition must specify the method and basis for the issuance of the converted stock company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the converted stock company to a sound financial condition.

(3) The conversion may be accomplished without payment of consideration to past, present or future policyholders, but only if the petition makes such a specific request and the commissioner finds that the value of the mutual insurance company is insufficient to warrant that consideration.

**SOURCES: Laws, 1998, ch. 576, § 19, eff from and after July 1, 1998.**

## § 83-31-141. Requirements for acquiring control; converted company rights, privileges and compliance.

(1) A mutual insurance company may not be permitted to convert under Sections 83-31-101 through 83-31-143 if, as a direct result of the conversion, any person or any affiliate acquires control of the converted stock company, unless that person or the affiliate complies with the requirements of Section 83-6-1 et seq.

(2) Except as otherwise specified in Sections 83-31-47 or 83-31-101 through 83-31-181, a converted stock company has all of the rights and privileges and is subject to all of the requirements and regulations imposed on stock companies formed under the laws of this state but may not exercise rights or privileges that other stock companies may not exercise.

**SOURCES: Laws, 1998, ch. 576, § 20, eff from and after July 1, 1998.**

## § 83-31-143. Endorsement or rider extinguishing policy rights.

A mutual insurance company, by endorsement or rider approved by the commissioner and delivered to the policyholder, may simultaneously with or at any time after the adoption of a conversion plan amend any outstanding insurance policy to evidence the extinguishment of the rights, if any, of the holder of the policy as described in the plan of conversion approved by the commissioner. However, such an amendment is void if the conversion plan does not take effect.

**SOURCES: Laws, 1998, ch. 576, § 21, eff from and after July 1, 1998.**

## § 83-31-145. Definitions applicable to mutual insurance holding company provisions.

As used in Sections 83-31-145 through 83-31-181, the following items shall have the meaning ascribed herein unless the context indicates otherwise:

(a) "Mutual insurance holding company" means an incorporated entity without permanent capital stock that is organized under Section 83-31-145 et seq. and whose members are determined in accordance with such provisions.

(b) "Subsidiary insurance company" means a stock insurance company, the majority of the voting shares of the capital stock of which are at all times owned by a mutual insurance holding company. For these purposes, "majority of the voting shares of the capital stock" means shares of the capital stock of a company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock for the election of directors, other than securities having voting power only because of the occurrence of a contingency. The ownership of a majority of the voting shares of the capital stock of a former mutual insurance company reorganized under Sections 83-31-145 through 83-31-181 which voting shares are required by Sections 83-31-145 through 83-31-181 to be at all times owned by a mutual insurance holding company includes indirect ownership through one or more intermediate holding companies. However, indirect ownership through one or more intermediate holding companies shall not result in a mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the former mutual reorganized insurance company.

(c) "Intermediate holding company" means a holding company which is a subsidiary of a mutual insurance holding company and which directly or through a subsidiary intermediate holding company owns a majority of the voting shares of the capital stock of one or more subsidiary insurance companies.

(d) "Plan of reorganization" means a plan adopted under Sections 83-31-145 through 83-31-181 by the board of directors of a domestic mutual insurance company to reorganize as provided in Section 83-31-151.

(e) "Mutual insurance company" means a domestic mutual insurance company formed pursuant to Section 83-31-1 et seq. except for domestic mutual insurance companies that have active life insurance or annuities products in force.

**SOURCES: Laws, 1998, ch. 576, § 22, eff from and after July 1, 1998.**

## § 83-31-147. Holding company voting share ownership; securities issuance.

(1) The voting shares of the capital stock of a subsidiary insurance company, which are required by Sections 83-31-145 through 83-31-181 in order to maintain a majority of the voting shares, are to be at all times owned by a mutual insurance holding company or one or more intermediate holding companies and the voting shares of the capital stock of any intermediate holding company, which are necessary to satisfy such ownership requirement through indirect ownership, shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered or otherwise hypothecated or alienated by the mutual insurance holding company or any intermediate holding company, except with the prior approval of the commissioner. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation of, in or on such voting shares of capital stock is in violation of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation as to such shares of capital stock. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two (2) or more subsidiary insurance companies or two (2) or more intermediate holding companies which were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this section to which the shares of the merging or consolidating

former mutual reorganized insurance companies or intermediate holding companies were subject by this section before the merger or consolidation.

(2) Upon approval of the commissioner and compliance with applicable law, an intermediate holding company or a subsidiary insurance company may issue to the mutual insurance holding company and to other persons securities, including voting stock, nonvoting stock and securities convertible into voting or nonvoting stock, if, after giving effect to such issuance, in the aggregate, the issued and outstanding voting stock of the intermediate holding company or the subsidiary insurance company held directly or indirectly by the mutual insurance holding company is not less than a majority of the voting shares of capital stock of such intermediate holding company or subsidiary insurance company. For purposes of this limitation, any issued and outstanding securities of an intermediate holding company or subsidiary insurance company that are convertible into voting stock shall be considered issued and outstanding voting stock. Upon approval of the commissioner and compliance with applicable law, an intermediate holding company or a subsidiary insurance company may issue any such securities: (a) to policyholders of a subsidiary insurance company in accordance with a subscription offering containing such terms, conditions and limitations as are approved by the board of directors of such intermediate holding company or subsidiary insurance company and the mutual insurance holding company; (b) in a public offering; or (c) in a private placement, including, without limitation, to one or more purchasers who are holders of surplus notes or other securities of a subsidiary insurance company, have or will have a lending, pooling or reinsurance arrangement with a subsidiary insurance company, have or will have an insurance, marketing, investment, support or other cooperative arrangement or affiliation with the subsidiary insurance company or are an affiliate of any entity which has such a relationship.

**SOURCES: Laws, 1998, ch. 576, § 23, eff from and after July 1, 1998.**

## § 83-31-149. Domestic mutual insurance holding company powers and compliance with nonprofit private corporation provisions.

Domestic mutual insurance holding companies shall have all the powers and authority and shall be subject to the requirements applicable to Mississippi nonprofit private corporations under Section 79-11-101 et seq., except:

(a) A mutual insurance holding company shall be organized exclusively under Sections 83-31-145 through 83-31-181 and shall be a mutual company without capital stock.

(b) The articles of association of the mutual insurance holding company and any amendment to such articles or restatement of such articles shall be subject to the approval of the commissioner for compliance with the provisions of Sections 83-31-145 through 83-31-181 before filing with the Mississippi Secretary of State and shall contain the name of the mutual insurance holding company, which shall include the word "mutual."

(c) To the extent that the provisions of Section 79-11-101 et seq. conflict with the provisions of Sections 83-31-47 or 83-31-101 through 83-31-181, the insurance laws of the State of Mississippi or the regulations of the commissioner, then such provisions of Sections 83-31-47 or 83-31-101 through 83-31-181, the insurance laws of the State of Mississippi or the regulations of the commissioner shall control.

**SOURCES: Laws, 1998, ch. 576, § 24, eff from and after July 1, 1998.**

## § 83-31-151. Reorganization and subsidiaries.

(1) A domestic mutual insurance company, by itself or together with one or more other mutual insurance companies, under a plan of reorganization, may reorganize as a mutual insurance holding company system that must consist of a mutual insurance holding company and one or more controlled subsidiaries and which may consist of one or more intermediate stock holding companies and other subsidiaries as permitted by Section 83-6-1 et seq. The reorganization may be effected by the organization of one or more companies, amendment or restatement of the articles of association and bylaws of one or more companies, transfer of assets and liabilities among two (2) or more companies, issuance, acquisition or transfer of capital stock of one or more companies or merger or consolidation of two (2) or more companies. On and after the effective date of a plan of reorganization, the mutual insurance holding company shall at all times own, directly or indirectly, a majority of the voting shares of each controlled subsidiary and any intermediate stock holding company.

(2) All of the initial shares of the capital stock of the insurance company which reorganized as a subsidiary insurance company shall be issued either to the mutual insurance holding company or to an intermediate holding company which is wholly owned by the mutual insurance holding company. This restriction does not preclude the subsequent issuance of additional shares of stock by an intermediate holding company or the subsidiary insurance company, subject to the approval of the commissioner and compliance with applicable law, so long as the mutual insurance holding company at all times owns directly or through one or more intermediate holding companies, a majority of the voting shares of the capital stock of the subsidiary insurance company. The membership interests of the policyholders of the subsidiary insurance company shall become membership interests in the mutual insurance holding company in accordance with the plan of reorganization. Policyholders of the subsidiary insurance company which was formerly the mutual insurer shall be members of the mutual insurance holding company in accordance with the plan of reorganization and the articles of association and bylaws of the mutual insurance holding company.

**SOURCES: Laws, 1998, ch. 576, § 25, eff from and after July 1, 1998.**

## § 83-31-153. Reorganization plan requirements; adoption and approval.

(1) A plan of reorganization shall include the following provisions:

(a) A description of the structure of the proposed mutual insurance holding company system consistent with the requirements therefor set forth in Sections 83-31-145 through 83-31-181.

(b) A description of the qualifications for membership in and the rights of members of the mutual insurance holding company consistent with the requirements therefor set forth in Sections 83-31-145 through 83-31-181, provisions for the extinguishment of membership interests in the mutual insurance company and provisions for the conversion of such membership interests in the mutual insurance company into membership interests in the mutual insurance holding company.

(c) A description of the transactions, and parties to such transactions, that will effect the reorganization, including, but not limited to, transfer and assumption of policies, contracts, assets and liabilities.

(d) A description of corporate restructuring and other corporate transactions that will effect the reorganization, including, but not limited to, formation or organization of companies, amendment or restatement of articles of association or bylaws or those proposed in connection with the formation or organization of companies in connection with the plan and mergers and consolidations.

(e) A description of those persons who shall serve as directors and officers of the mutual insurance holding company, its intermediate stock holding companies, if any, its controlled subsidiaries and other subsidiaries as of the effective date of the reorganization. The initial directors of each such company shall be the directors of the mutual insurance company who shall have terms concurrent with the terms as directors of the reorganized mutual insurance company unless otherwise specified in the plan.

(f) Provisions requiring that, following the reorganization, the material terms and conditions of indemnification or coverage of policyholders of the mutual insurance company shall remain in full force and effect under policies transferred to and assumed by one or more subsidiaries of the mutual insurance holding company.

(g) Provisions requiring that, following the reorganization, the material terms and conditions of subordinated surplus notes and other contractual obligations, other than those arising under policies described in paragraph (f) of this section, of the mutual insurance company, subject to the rights of the mutual insurance company under applicable law, and to the extent such obligations are not otherwise satisfied or terminated in accordance with their terms or retained by a mutual insurance holding company or controlled subsidiary, shall remain in full force and effect upon the transfer of such obligations to, and assumption of such obligations by, one or more subsidiaries of the mutual insurance holding company.

(2) A plan of reorganization must be adopted by two-thirds (⅔) of the members of the board of directors of the mutual insurance company or, in the

case of the formation of any intermediate stock insurance holding company that is not concurrent with the formation of the mutual insurance holding company, by two-thirds (⅔) of the members of the board of directors of the mutual insurance holding company.

(3) Not later than the ninetieth day following the adoption of a plan of reorganization by the board of directors, and before the meeting of the mutual insurance company members to approve the plan, the mutual insurance company shall submit to the commissioner the following:

(a) The plan of reorganization, as adopted.

(b) The form of notice to be sent to the mutual insurance company members, informing them of their right to vote on the plan of reorganization.

(c) The form of proxy statement to be sent to the mutual insurance company members informing them of their right to vote by proxy on the plan of reorganization and describing the plan.

(d) The form of proxy to be sent to the mutual insurance company members to solicit their vote on the plan of reorganization.

(e) Proposed articles of association, merger or consolidation, bylaws, restatements of or amendments to articles of association and bylaws and plans of merger or consolidation with respect to each entity to be organized, reorganized or otherwise subject to such action under the plan of reorganization.

(f) An audited financial statement prepared on a statutory basis in accordance with the insurance laws of the State of Mississippi, including an actuarial opinion for the most recent calendar year ended, or a copy thereof, if the statement was previously filed with the commissioner.

(g) Such other information as required under rules or regulations or as requested by the commissioner.

(4) The commissioner may hold a public hearing to allow public comment on the plan of reorganization after giving written notice to the mutual insurance company and other interested persons, all of whom have the right to appear at the hearing. Notice to interested persons who have not filed an appearance in the matter may be made in any reasonable manner deemed appropriate by the commissioner with the costs thereof assessed to the mutual insurance company.

(5)(a) Within twenty (20) business days after filing with the commissioner the documents required in connection with a plan of reorganization, the mutual insurance company shall send to each eligible member a notice advising the eligible member of the adoption and filing of the plan of reorganization and of the member's right to provide to the commissioner and the mutual insurance company comments on the plan.

(b) As an alternative to the notice required under paragraph (a) of this subsection, the mutual insurance company may use any other means which is reasonably designed to provide notice to eligible members and which alternative means of providing notice is approved by the commissioner.

(c) The notice required under paragraph (a) or (b) of this subsection shall include a description of the procedure to be used in making comments.

(d) An eligible member who elects to make comments must make the comments in writing (i) if notice is sent to each eligible member, not later than the thirtieth day after the date on which the notice is sent, or (ii) if an alternative means of providing notice is approved by the commissioner, not later than such date for receipt of comments approved by the commissioner.

(6) Except as otherwise provided by this subsection, the commissioner shall approve or disapprove a plan of reorganization not later than the ninetieth day after the first day on which all the documents and other information required are filed with the commissioner. The commissioner may not extend the time for approval or disapproval beyond the ninety-day time period unless he finds it necessary to retain a qualified expert in accordance with subsection (7) of this section, in which case he may extend the time for review for an additional sixty (60) days beyond the initial ninety-day period. Notwithstanding the stated time limits herein, the commissioner may extend the time for approval or disapproval for an additional thirty (30) days beyond the date on which any amendment to such plan is filed with the commissioner. The commissioner shall, within five (5) days of approving or disapproving a plan of reorganization, give written notice to the mutual insurance company of the commissioner's decision and, in the event of disapproval, a detailed statement of the reasons for the adverse decision. If a plan is disapproved, then the plan of reorganization may be amended and resubmitted to the commissioner for his approval or disapproval as provided in Sections 83-31-145 through 83-31-181. If the commissioner disapproves the plan then the mutual insurance company may appeal the commissioner's decision as provided by the laws of this state to the Chancery Court of the First Judicial District of Hinds County, Mississippi.

(7) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist the commissioner in reviewing the plan of reorganization.

(8) The commissioner shall approve a plan of reorganization if the commissioner finds that the plan of reorganization complies with Sections 83-31-145 through 83-31-181 and the plan of reorganization is fair and equitable to members and policyholders; however, the commissioner may not approve such a plan of reorganization and shall disapprove such a plan if the commissioner finds that (a) the effect of the plan of reorganization would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein; (b) the financial condition of any party to the plan of reorganization is such as might jeopardize the financial stability of the insurers which are parties to the plan, or prejudice the interests of their policyholders; (c) the plan of reorganization or the plans for operation of the parties to the plan of reorganization following implementation of the plan of reorganization are not in the public interest; (d) the competence, experience and integrity of those persons who would control the operations of the parties to the plan of reorganization are such that it would not be in the interest of policyholders of the parties to the plan of reorganization or of the public to

permit the plan of reorganization; (e) the plan of reorganization's method of allocating value is not fair and equitable; (f) the plan of reorganization is not fair and equitable to the members and policyholders; (g) implementation of the plan of reorganization is likely to be hazardous or prejudicial to the insurance buying public; or (h) the plan of reorganization unfairly enriches the officers and directors of the reorganizing insurer.

(9)(a) A plan of reorganization adopted by the board of directors of the mutual insurance company may be:

(i) Amended by the board of directors of the mutual insurance company in response to the comments or recommendations of the commissioner or any other state or federal agency or governmental entity before any solicitation of proxies from members of the mutual insurance company to vote on the plan of reorganization or at any time with the consent of the commissioner, except that any material amendment after the members' approval shall require the members' approval; or

(ii) Terminated by the board of directors of the applicant at any time before members of the mutual insurance company vote on the plan of reorganization and, otherwise, at any time with the consent of the commissioner.

(b) The plan of reorganization is approved upon the affirmative vote of at least two-thirds (⅔) of the votes cast by members of the mutual insurance company, notwithstanding quorum or voting action requirements otherwise applicable to the mutual insurance company to the contrary.

(c) Within thirty (30) days after members have approved the plan of reorganization, the applicant must file with the commissioner the minutes of the meeting at which the plan of reorganization was approved.

**SOURCES: Laws, 1998, ch. 576, § 26, eff from and after July 1, 1998.**

## § 83-31-155. Dividends and distributions to members.

A mutual insurance holding company shall not be authorized to pay dividends or make distributions to mutual insurance holding company members except as may be expressly approved by the commissioner. Neither the adoption nor the implementation of a plan of reorganization leading to the formation of a mutual holding company shall be deemed to give rise to any obligation by or on behalf of a mutual insurance company to make any distribution or payment to any member or policyholder or to any other person, fund or entity of any nature whatsoever in connection with the ownership, control, benefits, policies, purpose, or nature of the mutual insurance company or otherwise.

**SOURCES: Laws, 1998, ch. 576, § 27, eff from and after July 1, 1998.**

## § 83-31-157. Holding company merger or consolidation.

(1) Subject to applicable requirements of Sections 83-31-47 and 83-31-101 through 83-31-181 and Section 83-6-1 et seq., a mutual insurance holding company may:

(a) Merge or consolidate with, or acquire the assets of, a mutual insurance holding company formed under Sections 83-31-47 or 83-31-101 through 83-31-181 or any similar entity or organization formed under the laws of any other state;

(b) Either alone or together with one or more intermediate stock holding companies, or other subsidiaries, directly or indirectly acquire the stock of a stock insurance company or a mutual insurance company that reorganizes under Sections 83-31-47 or 83-31-101 through 83-31-181 or the law of its state of organization;

(c) Together with one or more of its stock insurance company subsidiaries, acquire the assets of a stock insurance company or a mutual insurance company;

(d) Acquire a stock insurance company through the merger of such stock insurance subsidiary with a stock insurance company or intermediate stock insurance company subsidiary of the mutual insurance holding company; or

(e) Acquire the stock or assets of any other person to the same extent as would be permitted for a mutual insurance company.

(2)(a) A plan and agreement for merger or consolidation in accordance with subsection (1) of this section shall be submitted to and approved by two-thirds (⅔) of the members of each domestic mutual insurance holding company or mutual insurance company involved in the merger or consolidation who vote either in person or by proxy thereon at meetings called for the purposes pursuant to such reasonable notice and procedure as has been approved by the commissioner; however, no vote of a domestic mutual insurance holding company shall be required to approve the merger of a mutual insurance holding company which has resulted from the reorganization of a domestic or foreign mutual insurance company and which has surplus equal to not more than twenty-five percent (25%) of the surplus of the combined companies.

(b) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the commissioner and approved by the commissioner in accordance with Section 83-6-1 et seq.

(c) All of the initial shares of the capital stock of the reorganized subsidiary insurance company shall be issued either to the mutual insurance holding company, or to an intermediate holding company which is a subsidiary of the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation and the articles of association and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times directly or indirectly own a majority of the voting shares of the capital stock of any reorganized subsidiary insurance company.

**SOURCES: Laws, 1998, ch. 576, § 28, eff from and after July 1, 1998.**

**Cross References** — Mutual insurance holding company investments, see § 83-31-167.

## § 83-31-159. Filing and approval of articles of association.

(1) No mutual insurance holding company shall be formed unless its articles of association are approved by the commissioner before filing the articles of association with the Mississippi Secretary of State as provided by law.

(2) The articles of association shall be effective when filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the articles of association as filed.

**SOURCES: Laws, 1998, ch. 576, § 29, eff from and after July 1, 1998.**

## § 83-31-161. Amending articles of association.

(1) A domestic mutual insurance holding company may amend its articles of association by vote of a majority of those members present or represented by proxy at a lawful meeting of its members if the notice given members included due notice of the proposal to amend.

(2) Upon adoption of an amendment, the articles of amendment shall be effective when filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the articles of amendment.

**SOURCES: Laws, 1998, ch. 576, § 30, eff from and after July 1, 1998.**

## § 83-31-163. Bylaws.

(1) The initial board of directors of a mutual insurance holding company shall adopt bylaws.

(2) The bylaws shall provide:

(a) That each member is entitled to one (1) vote upon each matter coming to a vote at meetings of members or to more votes in accordance with a reasonable classification of members as set forth in the bylaws and based upon the amount of insurance in force with the mutual insurance holding company's subsidiaries or upon the amount of the premiums paid to the mutual insurance holding company's subsidiaries by such member or upon other reasonable factors. The bylaws shall provide that a member has the right to vote in person or by his written proxy. The bylaws may specify the mode of voting by proxy and other requirements relating to voting by proxy consistent with procedures used by mutual insurance companies in accordance with Section 83-31-9 et seq.

(b) For the election of directors by the members and the number, qualifications, terms of office, subject to the requirements of Section 83-31-165.

(c) For the time, notice and conduct of annual and special meetings of members and voting thereat.

(d) For the number, designation, election, terms and powers and duties of the respective corporate officers.

(e) For deposit, custody and disbursement of and accounting for corporate funds.

(f) That a quorum at all annual and special meetings of members shall consist of all members present and voting in person or by proxy, after due notice of such meeting.

(g) For any other reasonable provisions customary, necessary or convenient for the management or regulation of the company's corporate affairs not inconsistent with law.

(3) Within thirty (30) days of adoption of any bylaws or any modification thereof or addition thereto, a mutual insurance holding company shall file with the commissioner a copy, certified by the mutual insurance holding company's secretary, of such bylaws and of every modification thereof or addition thereto, which shall be subject to the approval of the commissioner. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision disapproved by the commissioner.

**SOURCES: Laws, 1998, ch. 576, § 31, eff from and after July 1, 1998.**

## § 83-31-165. Directors.

(1) The affairs of every mutual insurance holding company shall be managed by not less than five (5) directors.

(2) Directors shall be elected by the members of the mutual insurance holding company at the annual meeting of members. Directors may be elected for terms of not more than three (3) years each and until their successors are elected and have qualified, and, if to be elected for terms of more than one (1) year, the mutual insurance holding company's bylaws may provide for a classified board under which the terms of a proportionate part of the members of the board of directors shall expire on the date of each annual meeting of members.

(3) If so provided in a mutual insurance holding company's bylaws, a director of such mutual insurance holding company must be a policyholder of a subsidiary insurance company of the mutual insurance holding company.

**SOURCES: Laws, 1998, ch. 576, § 32, eff from and after July 1, 1998.**

## § 83-31-167. Dissolution, liquidation, commissioner jurisdiction and investments.

(1) A mutual insurance holding company and, if applicable, an intermediate holding company shall not be dissolved or liquidated without the approval of the commissioner.

(2) The commissioner shall retain jurisdiction over a mutual insurance holding company incorporated in this state and, if applicable, an intermediate holding company, to assure that policyholder interests are protected, including, but not limited to, regulation of the solvency of such companies.

(3) Subject to the limitations of Section 83-6-2, a mutual insurance holding company formed under Sections 83-31-47 or 83-31-101 through 83-31-181 may (a) invest in the stock or debt securities of one or more intermediate holding companies; (b) invest in the stock or debt securities of one or more domestic or foreign insurance companies; (c) exercise any power or engage in any transaction or activity permitted by Section 83-31-157 or other provision applicable to mutual insurance holding companies; and (d) invest in any corporation, partnership, limited liability company, business trust or other entity permitted for a mutual insurance company under the laws of this state.

**SOURCES: Laws, 1998, ch. 576, § 33, eff from and after July 1, 1998.**

## § 83-31-169. Membership requirements.

(1) Membership in a mutual insurance holding company shall be determined in accordance with the mutual insurance holding company's articles of association and bylaws and, subject to such exceptions as are set forth in the articles of association or bylaws, shall be based upon each member's holding a policy of insurance with a subsidiary insurance company.

(2) Any person, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a mutual insurance holding company.

(3) No member of a mutual insurance holding company may transfer membership or any right arising therefrom.

(4) A member of a mutual insurance holding company is not, as such, personally liable for the acts, debts, liabilities or obligations of the company and may not be assessed by the directors of such company.

(5) A membership interest in a mutual insurance holding company shall not constitute a security as defined by Section 75-71-105 and shall not be subject to any requirements of the Mississippi Securities Act, Section 75-71-101 et seq.

**SOURCES: Laws, 1998, ch. 576, § 34, eff from and after July 1, 1998.**

## § 83-31-171. Voluntary dissolution.

(1) Upon any voluntary dissolution of a domestic mutual insurance holding company, its assets remaining after discharge of its indebtedness, if

any, and expenses of administration shall be distributed to existing persons who were its members at any time within the three-year period preceding the date such liquidation was authorized or ordered or date of last termination of the insurer's certificate of authority, whichever date is earlier; except, if the commissioner has reason to believe that those in charge of the management of the mutual insurance holding company have caused or encouraged the reduction of the number of members of the insurer in anticipation of liquidation and for the purpose of reducing thereby the number of persons who may be entitled to share in distribution of the insurer's assets, the commissioner may enlarge the three-year qualification period by such additional time as the commissioner may deem to be reasonable.

(2) The distributive share of each such member shall be determined by a formula based upon such reasonable classifications of members as the commissioner may approve.

**SOURCES: Laws, 1998, ch. 576, § 35, eff from and after July 1, 1998.**

## § 83-31-173. Provisions applicable to mutual insurance holding companies; exemptions from certain provisions.

Each mutual insurance holding company shall be subject to the applicable laws and rules of this state relating to insurance holding company systems. A mutual insurance holding company shall not be subject to provisions of Title 83 of the Mississippi Code or rules adopted thereunder with respect to the writing of insurance or required capital or surplus. A mutual insurance holding company system shall be considered an insurance holding company system but shall not require separate approval under Section 83-31-1 et seq. for an acquisition of controlling stock, ownership interest, assets or control or for a merger or consolidation, share exchange, organization, or reorganization of insurance companies or other transaction with respect to any action approved under the provisions of Sections 83-31-47 or 83-31-101 through 83-31-181.

**SOURCES: Laws, 1998, ch. 576, § 36, eff from and after July 1, 1998.**

## § 83-31-175. Actions challenging validity.

An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a plan of reorganization under Sections 83-31-47 or 83-31-101 through 83-31-181 must begin in the Chancery Court of the First Judicial District of Hinds County, Mississippi, not later than the thirtieth day after the effective date of the plan of reorganization.

**SOURCES: Laws, 1998, ch. 576, § 38, eff from and after July 1, 1998.**

## § 83-31-177. Mutual insurance holding company conversion to stock holding company.

A mutual insurance holding company may become a stock holding company under such plan and procedure as may be approved by the commissioner and as provided in Section 83-31-101 et seq.

**SOURCES: Laws, 1998, ch. 576, § 37, eff from and after July 1, 1998.**

## § 83-31-179. Fees, costs and expenses.

(1) A director, officer, agent or employee of the mutual insurance company may not receive a fee, commission or other consideration other than that person's usual salary or compensation for aiding, promoting or assisting in a plan of reorganization under Sections 83-31-47 or 83-31-101 through 83-31-181, except as provided by the plan of reorganization approved by the commissioner.

(2) All the costs and expenses connected with a plan of reorganization shall be paid for or reimbursed by the mutual insurance company or the mutual insurance holding company.

**SOURCES: Laws, 1998, ch. 576, § 39, eff from and after July 1, 1998.**

## § 83-31-181. Rules and regulations.

The commissioner may adopt rules and regulations implementing the provisions of Sections 83-31-101 through 83-31-179, including, but not limited to, the regulation of the solvency of mutual insurance holding companies and intermediate holding companies.

**SOURCES: Laws, 1998, ch. 576, § 40, eff from and after July 1, 1998.**

# CHAPTER 33

## Reciprocal Insurance

Sec.
83-33-1. Regulation of exchange.
83-33-3. Execution of contracts.
83-33-5. Declaration under oath.
83-33-7. Commissioner as agent for service of process.
83-33-9. Maximum risk.
83-33-11. Assets maintained.
83-33-13. Financial reports.
83-33-15. Penalty.
83-33-17. Certificate of authority.
83-33-19. Taxation of premium receipts.

### § 83-33-1. Regulation of exchange.

Individuals, partnerships and corporations of this state, designated as subscribers, may exchange reciprocal or interinsurance contracts with each other or with individuals, partnerships and corporations of other states and countries, providing indemnity among themselves from any loss which may be insured against under other provisions of the law except life insurance.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209t; 1930, § 5291; 1942, § 5805; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 1, eff from and after July 1, 1995.**

#### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 127, 132.

**CJS.** 46 C.J.S., Insurance § 1946.

### § 83-33-3. Execution of contracts.

Such contracts may be executed by an attorney, agent, or other representative, herein designated attorney, duly authorized and acting for said subscribers, and such attorney may be a corporation. The office or offices of such attorney may be maintained at such place or places as may be designated by the subscribers in the power of attorney.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209u; 1930, § 5292; 1942, § 5806; Laws, 1918, ch. 190.**

**Cross References** — Exclusion of reciprocal contracts from requirement that insurance policies be written by resident local agents, see § 83-17-21.

#### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 133.

**CJS.** 46 C.J.S., Insurance § 1948.

## § 83-33-5. Declaration under oath.

Such subscribers so contracting among themselves shall, through their attorney, file with the insurance commissioner a declaration verified by the oath of such attorney or, where such attorney is a corporation, by the oath of the proper officer thereof, setting forth:

(a) The name of the attorney and the name or designation under which such contracts are issued, which name or designation shall not be so similar to any name or designation adopted by any attorney or by an insurance organization in the United States writing the same class of insurance prior to the adoption of such name or designation by the attorney as to confuse of deceive.

(b) The kind or kinds of insurance to be effected or exchanged.

(c) A copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged.

(d) A copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged.

(e) The location of office or offices from which such contracts or agreements are to be issued.

(f) That applications have been made for indemnity upon at least seventy-five (75) separate risks aggregating not less than One and One-half Million Dollars ($1,500,000.00), as represented by executed contracts or bona fide applications to become concurrently effective; or in case of employers' liability or similar classes of insurance, covering a total payroll of not less than Two and One-half Million Dollars ($2,500,000.00).

(g) That there is in the possession of such attorney and available for the payment of losses, assets conforming to Section 83-33-11.

(h) A financial statement in form prescribed for the annual statement.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209v; 1930, § 5293; 1942, § 5807; Laws, 1918, ch. 190.**

**Cross References** — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 128-141.

**CJS.** 46 C.J.S., Insurance §§ 1945 et seq.

## § 83-33-7. Commissioner as agent for service of process.

Concurrently with the filing of the declaration provided by the terms of Section 83-33-5, the attorney shall file with the insurance commissioner an instrument in writing, executed by him for said subscribers, conditioned that upon the issuance of certificates of authority provided in Section 83-33-17 action may be brought in the county in which the property or person insured thereunder is located, and service of process may be had upon the insurance commissioner in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon all subscribers exchanging at any time reciprocal or inter-insurance contracts through such attorney. Three (3) copies of each process shall be served, and the insurance commission shall file one (1) copy, forward one (1) copy to said attorney, and return one copy with his admission of service. A judgment rendered in any such case where service of process has been so had upon the insurance commissioner shall be valid and binding against any and all such subscribers as their interests appear, and such judgment may be satisfied out of the funds in the possession of the attorney belonging to such subscribers.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209w; 1930, § 5294; 1942, § 5808; Laws, 1918, ch. 190.**

**Editor's Note** — Section 83-3-2 provides that any reference to "insurance commission" in Title 83 shall mean the Commissioner of Insurance.

**Cross References** — Notification of attorney following service of process upon commissioner, see § 83-5-11.

For the rule controlling service of process on reciprocal insurance companies, see Miss. Rule of Civil Proc. 4.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 139.

**CJS.** 46 C.J.S., Insurance § 1962.

## § 83-33-9. Maximum risk.

There shall be filed with the insurance commissioner by such attorney, whenever the insurance commissioner shall so require, a statement under the oath of such attorney showing in the case of fire insurance the maximum amount of indemnity upon a single risk; and no subscriber shall assume on any single fire insurance risk an amount greater than ten percent (10%) of the net worth of such subscriber.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209x; 1930, § 5295; 1942, § 5809; Laws, 1918, ch. 190.**

**Editor's Note** — Section 83-3-2 provides that any reference to "insurance commission" in Title 83 shall mean the Commissioner of Insurance.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 134-138.

**CJS.** 46 C.J.S., Insurance § 1951.

## § 83-33-11. Assets maintained.

(1) There shall be maintained at all times assets in cash or securities authorized by the laws of this state for the investment of funds of insurance

companies doing the same kind of business, an amount equal to one hundred percent (100%) of the unearned premiums or deposits collected and credited to the accounts of subscribers, or fifty percent (50%) of the advance premiums or deposits collected and credited to the accounts of subscribers on policies having one (1) year or less to run, pro rata on those for longer periods. In addition to the foregoing sum in the case of liability insurance, there shall be maintained as a reserve assets sufficient to discharge all liabilities on all outstanding claims, both reported and incurred but not reported, arising under all policies issued, the same to be calculated on the basis of premiums or deposits as in this section defined and in accordance with the laws of the state relating to similar reserves for companies insuring similar risks. Premiums or deposits as used in this section shall be construed to mean the advance payments made by subscribers. If at any time the assets on hand are less than the foregoing requirements or less than One Hundred Thousand Dollars ($100,000.00), whichever is the greater, where the attorney is exchanging contracts covering employers' liability or similar classes of insurance, the subscribers shall make up the deficiency. Whenever such assets are less than the amount above required or less than Fifty Thousand Dollars ($50,000.00), whichever is the greater, if the attorney is exchanging contracts other than those covering employers' liability or similar classes of insurance, the subscribers shall make up the deficiency.

(2) Reserve requirements are determined in accordance with those of similar companies insuring similar risks.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209y; 1930, § 5296; 1942, § 5810; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 2, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 71, 72.

**CJS.** 44 C.J.S., Insurance §§ 121-123, 132, 133.

## § 83-33-13. Financial reports.

Such attorney shall, within the time limited for filing the annual report by insurance companies transacting the same kind of business, make a report to the insurance commissioner for each calendar year showing the financial condition of affairs at the office where such contracts are issued, and shall furnish such additional information and reports as may be required to show the total premiums or deposits collected, the total losses paid, the total amounts returned to subscribers, and the amounts retained for expenses, provided, however, that such attorney shall not be required to furnish the names and addresses of any subscribers. The business affairs and assets of such organization shall be subject to examination by the insurance commissioner at the expense of the office examined.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209z; 1930, § 5297; 1942, § 5811; Laws, 1918, ch. 190.**

**Cross References** — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance §§ 96, 128.

## § 83-33-15. Penalty.

Any attorney who shall exchange any contracts of insurance of the kind and character specified in this chapter or any attorney or representative of such attorney who shall solicit or negotiate any application for same without the attorney first complying with the foregoing provisions shall be deemed guilty of a misdemeanor and, on conviction thereof, shall be subjected to a fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00). For the purpose of organization and upon issuance of permit by the insurance commissioner, powers of attorney may be solicited without license; but no attorney, agent, or other persons shall effect any such contracts of insurance until all the provisions of this chapter shall have been complied with.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209a1; 1930, § 5298; 1942, § 5812; Laws, 1918, ch. 190.**

**Cross References** — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 127, 132.

**CJS.** 46 C.J.S., Insurance § 1946.

## § 83-33-17. Certificate of authority.

Upon compliance with the foregoing requirements and the payment of the fees and taxes provided in this chapter, the insurance commissioner shall issue a certificate of authority to the attorney in the name and title mentioned in subdivision (a) of Section 83-33-5. The insurance commissioner may revoke or suspend any certificate of authority issued hereunder in case of breach of any of the conditions imposed by this chapter after reasonable notice has been given such attorney in writing, so that he may appear and show cause why such action should not be taken. Any attorney who may have procured a certificate of authority hereunder may have same renewed annually thereafter, provided that any certificate of authority issued shall continue in force and effect until a new certificate of authority is issued or specifically refused.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209b1; 1930, § 5299; 1942, § 5813; Laws, 1918, ch. 190.**

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 127, 132.

**CJS.** 46 C.J.S., Insurance § 1946.

## § 83-33-19. Taxation of premium receipts.

Such attorney shall upon the issuance of the certificate of authority herein provided pay to the state the sum of two hundred dollars ($200.00), as provided in Section 27-15-83, and with the filing of the annual report herein provided shall pay an annual tax upon the gross premiums or deposits collected from subscribers in this state during the preceding calendar year, after deducting therefrom returns for cancellations, considerations for reinsurance, and all amounts returned to subscribers or credited to their account as savings, as provided in Section 27-15-103 et seq.

**SOURCES: Codes, Hemingway's 1921 Supp. § 5209c1; 1930, § 5300; 1942, § 5814; Laws, 1918, ch. 190; Laws, 1978, ch. 441, § 6, eff from and after July 1, 1978.**

**Cross References** — Premium taxes imposed by privilege tax code, see §§ 27-15-103 et seq.

RESEARCH REFERENCES

**ALR.** Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 133.

**CJS.** 46 C.J.S., Insurance § 1948.

# CHAPTER 34

## Windstorm Underwriting Association

Sec.
83-34-1. Definitions.
83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.
83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment.
83-34-5. Powers and duties.
83-34-7. Designation of temporary board of directors; expiration of terms of office; permanent board of directors; composition of board; selection and qualifications of board members; terms of office; powers.
83-34-9. Participation by assessable insurers in regular assessments levied by association; financial incentives and/or penalties to ensure assessable insurers write insurance in the coast area.
83-34-10. Power to levy regular assessments upon occurrence of certain events; maximum total assessments.
83-34-11. Implementation of surcharge on all property and casualty premiums; exceptions; collection of surcharges; funds collected as surcharges to be used to reimburse assessable insurers for regular assessments; reimbursement to be refunded to association under certain conditions; audit of insurers; quarterly reports.
83-34-12. Deferment of assessable insurer's regular assessment; amount deferred to be assessed against other assessable insurers.
83-34-13. Plan of operation; contents; approval by commissioner; certification of approval; effective date of plan.
83-34-15. Application for coverage; inspection of property; issuance of insurance; appeal of denial of application.
83-34-16. Premium discount for building "fortified home."
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83-34-19. Appeals.
83-34-21. Reports of inspection made available.
83-34-23. Immunity from liability.
83-34-25. Annual report.
83-34-27. Commissioner may examine affairs of association; commissioner and association may examine data and payments of assessable insurer or insurers placing insurance through nonadmitted insurers.
83-34-29. Rules and regulations.
83-34-31. Powers and authority of board of directors to issue bonds and enter into loans or other forms of indebtedness; rights and remedies of bondholders not to be impaired.
83-34-33. Surcharge for excess hurricane losses on all property and casualty premiums; exempted premiums; purpose of certain surcharges to be designated and specifically identified; licensed insurers and agents to collect and remit surcharges; setting and adjustment of surcharge percentage; cessation of surcharge.
83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.
83-34-37. Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund created; purpose; use of funds; reports.

83-34-39. Repealed.

## § 83-34-1. Definitions.

In this chapter, unless the context otherwise requires:

(a) "Essential property insurance" means insurance against direct loss to property from the risk of windstorm and hail in the manner as defined and limited in the standard real property and contents insurance forms approved by the commissioner. Essential property insurance shall not include coverage for any loss other than the actual cash value of the structure and contents. Essential property insurance includes builders risks coverage. The extent of risk covered, the insuring language and the exclusions are all subject to approval by the commissioner. Policies, rules and rates shall be filed with the commissioner in the manner provided for insurance companies.

(b) "Association" means the Mississippi Windstorm Underwriting Association established pursuant to the provisions of this chapter.

(c) "Plan of operation" means the plan of operation of the association approved or promulgated by the commissioner pursuant to the provisions of this chapter.

(d) "Insurable property" means real property, and contents therein when requested, at fixed locations in the coast area, which property is determined by the association to be in an insurable condition and otherwise meets the underwriting requirements of the association. Any one- or two-family dwelling built, rebuilt, altered or remodeled in compliance with the applicable building codes, including design-wind requirements, that is not otherwise rendered uninsurable by reason of use, occupancy or state of repair, shall be an insurable risk. Neighborhood area, location and environmental hazards beyond the control of the applicant or owner of the property shall not be considered in determining insurable condition. "Insurable property" shall not include insurance on motor vehicles or creditor placed insurance on mobile homes. "Insurable property" includes mobile homes, modular homes or manufactured housing that are installed in compliance with applicable codes.

(e) "Commissioner" means the Insurance Commissioner of the State of Mississippi.

(f) "Coast area" means Hancock, Harrison, Jackson, Pearl River, Stone and George Counties.

(g)(i) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers for the year 2007, means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for the risk of windstorm and hail less return premiums upon cancelled contracts, dividends paid or credited to policyholders, or the unused or unabsorbed portion of premium deposits. "Net direct premiums" includes the premium charge component for the risk of windstorm and hail to property in all policies, including multi-peril and other policies that package or combine coverage for other risks. The plan of operation shall prescribe the portion of premium allocated for the risk of windstorm and hail in multi-peril and other policies that package or combine coverage for other risks. "Net direct premiums" shall not include farm property. "Net direct premiums" shall not include the property components of motor vehicles and other mobile property, but includes premiums for the risks of windstorm and hail for mobile homes, modular homes or manufactured housing.

(ii) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers after the year 2007, means those premiums reported by the assessable insurers in their annual statements to the Department of Insurance that were charged for insurance for any and all risks on real property and contents in the state. The department shall determine which lines of real property and contents insurance shall be included in the calculation of net direct premiums. The included real property and contents insurance lines may be changed from time to time in the discretion of the commissioner. "Net direct premiums" shall not include premiums for insuring farm property that are reported timely to the association as provided in the plan of operation.

(iii) The commissioner is authorized and directed to provide to the association annual statements, other reports and any statistics necessary to provide the information herein required and which the commissioner is hereby authorized and empowered to obtain from any assessable insurer.

(h) "Farm property" means property used for farming purposes; however, it shall not include any property used for dwelling purposes or any outbuildings used in connection therewith.

(i) "Losses" includes expenses for the adjustment and resolution of claims and operational and other general expenses.

(j) "Bonds, loans, lines of credit and indebtedness" include interest, finance charges, and any and all other costs associated with the financing.

(k) "Percentage of participation" for an assessable insurer means the percentage determined by dividing the assessable insurers net direct premiums written in this state in the previous year by the aggregate net direct premiums written in this state by all assessable insurers of the association in the previous year. The percentage of participation may be modified as provided in Sections 83-34-9(3) and 83-34-13(2).

(*l*) "Nonadmitted insurers" mean those insurance companies defined in Section 83-21-17, and any other companies and persons selling insurance on risks in Mississippi that are not licensed to do business in the State of Mississippi.

(m) "Agents placing insurance through nonadmitted insurers" means those agents defined in Section 83-21-19 and any other agents placing insurance through a nonadmitted insurer.

(n) "Assessable insurer" means each and every insurer authorized to write, and engaged in writing, property insurance within this state on a direct basis.

**SOURCES: Laws, 1987, ch. 459, § 2; Laws, 2007, ch. 425, § 5, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note —** Section 1, Chapter 459, Laws of 1987, provides as follows:

"SECTION 1. The Legislature of the State of Mississippi hereby declares that an adequate market for windstorm and hail insurance is necessary to the economic welfare of the State of Mississippi and that without such insurance the orderly growth and development of the State of Mississippi will be severely impeded; that furthermore, adequate insurance upon property in the coast area is necessary; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future. It is the purpose of this act [§§ 83-34-1 et seq.] to provide a mandatory program to assure an adequate market for windstorm and hail insurance in the coast area of Mississippi."

Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References —** Renewal of policies with respect to property meeting definition of "insurable property" under this section, see § 83-34-15.

## RESEARCH REFERENCES

**ALR.** Causes of loss under windstorm insurance coverage. 93 A.L.R.2d 145.

Temporary fire, wind, or hail insurance pending issuance of policy. 14 A.L.R.3d 568.

What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 482-484.

44A Am. Jur. 2d, Insurance §§ 1965, 1966, 2049.

**CJS.** 45 C.J.S., Insurance §§ 996, 998, 1285-1287, 1258, 1843, 1922.

**Law Reviews.** Hurricane Katrina Special Edition: Revamping the Wind Pool, 77 Miss. L.J. 795, Spring, 2008.

## § 83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.

(1) From and after March 22, 2007, the Mississippi Windstorm Underwriting Association, as created by Chapter 459, Laws of 1987, shall be a separate and independent entity as provided for herein. At its option, the association may incorporate. All assets belonging to the association on or before March 22, 2007, shall hereinafter belong to and remain with the association. There shall be no distribution of income or assets other than for the benefit of the association, which shall have the right to invest and reinvest assets.

(2) From and after March 22, 2007, the association shall no longer have members. Former "members" of the association shall be "assessable insurers" and shall have no rights to the assets and profits of the association, but shall have the obligation for regular assessments as provided herein. Former members shall continue to have the obligations provided in this chapter before March 22, 2007, for all policyholder claims, costs, damages of any kind and

expenses in any manner resulting from losses that occurred before March 22, 2007, for which the association may assess as needed the former members in the manner provided in this chapter before March 22, 2007. As a condition of its authority to continue to transact the business of insurance in this state and by transacting business in this state, each licensed insurer agrees to be bound by the provisions of this statute and the plan of operation as approved by the commissioner, and all amendments and revisions thereto.

(3) Any licensed insurer first authorized to write insurance after March 22, 2007, shall become an assessable insurer on the first day of January immediately following such authorization. The determination of such insurer's participation in the association shall be made based upon writings in the prior year in the same manner as for all other assessable insurers of the association.

(4) The premiums, assessments, fees, investment income and other revenue of the association are funds received for the sole purpose of providing insurance coverage, paying claims for Mississippi citizens insured by the association, securing and repaying debt obligations issued by the association, and conducting all other activities of the association, all as required or permitted by this chapter. Such revenue shall not be considered taxes, fees, licenses or charges for services imposed by the State of Mississippi on individuals, businesses, or agencies, and shall not be used for other purposes.

(5) It is the intent of the Legislature that the association be and act as a nonprofit entity. The association shall be free from taxation of every kind by the state and any political subdivision or other instrumentality thereof. It is the intent of the Legislature that the association be tax exempt from all taxes, including federal taxes, and the association is granted the authority to take those steps necessary to obtain federal tax exempt status.

(6) Any debt obligations issued by the association, their transfer, and the income therefrom, including any profit made on the sale thereof, shall at all times be free from taxation of every kind by the state and any political subdivision or other instrumentality thereof.

(7) In the event of the termination of the association by act of the Legislature, or other means, the assets of the association shall be applied first to pay all debts, liabilities and obligations of the association, including the establishment of reasonable reserves for any contingent liabilities or obligations, and all remaining assets of the association shall become property of the state.

(8) The association shall operate as a private enterprise and shall not be subject to the procurement provisions of Section 31-7-13, and policies and decisions of the association, including, but not limited to, decisions relating to incurring debt, levying of assessments, the issuance and sale of bonds, claims decisions under association policies, hiring and firing of employees, and all services relating to the operation of the association shall not be subject to the provisions of Section 25-9-101 et seq. The association shall not be required to obtain or to hold a license or certificate of authority issued by the commissioner or any other office. The association shall not be required to participate as a member insurer of the Mississippi Insurance Guaranty Association.

**SOURCES: Laws, 1987, ch. 459, § 3; Laws, 2007, ch. 425, § 6, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References** — Effect of insurer's writing any policies that require membership in association pursuant to this section, see § 83-34-9.

Powers and duties of association generally, see § 83-34-5.

Nonadmitted insurers are not assessable insurers of the association, see § 83-34-4.

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 69, 482-484.

44A Am. Jur. 2d, Insurance §§ 1965, 1966, 2049.

**CJS.** 45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

## § 83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment.

(1) Nonadmitted insurers shall not be assessable insurers of the association. All surplus lines insurance producers placing insurance through nonadmitted insurers shall collect from the insured and remit to the association a nonadmitted policy fee on all premiums collected after January 1, 2008, for all insurance written by such surplus lines insurance producer for a policy from a nonadmitted insurer for any and all risks in this state. By procuring or selling insurance on property in this state from a nonadmitted insurer, each surplus lines insurance producer placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy fee provided for herein.

(2) The nonadmitted policy fee shall be a percentage of the total policy premium but the nonadmitted policy fee shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the nonadmitted policy fee shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(3) The nonadmitted policy fee percentage shall be set by the commissioner. Such percentage may be changed from time to time in the discretion of the commissioner, but in no event shall the nonadmitted policy fee percentage be less than five percent (5%).

(4) Within twenty (20) days of the end of the quarter, surplus lines insurance producers placing insurance through nonadmitted insurers shall remit directly to the association all nonadmitted policy fees collected in the preceding quarter. In addition to the nonadmitted policy fee provided for herein, surplus lines insurance producers placing insurance through nonadmitted insurers shall collect and remit surcharges as provided by this chapter. Surplus lines insurance producers placing insurance through nonadmitted

insurers may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted carrier to collect and remit the nonadmitted policy fees.

(5) Each insured in this state who directly procures or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed, in whole or in part, in this state, other than insurance procured through a surplus lines licensee, shall be subject to the nonadmitted policy fee which shall be paid by the insured according to the procedures provided for premium taxes in Section 83-21-17(5).

**SOURCES: Laws, 2007, ch. 425, § 7; Laws, 2011, ch. 380, § 9, eff from and after passage (approved Mar. 11, 2011.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Amendment Notes** — The 2011 amendment substituted "surplus lines insurance producers" for "agents" throughout; deleted "on real property and contents" following "for any and all risks" near the end of the first sentence; deleted "subject to the procedures and requirements provided for premium taxes in Section 83-21-25" from the end of (4); and added (5).

## § 83-34-5. Powers and duties.

The association shall, pursuant to the provisions of this chapter and the plan of operation, and with respect to essential property insurance on insurable property, have the power:

(a) To issue policies of essential property insurance on insurable property to applicants;

(b) At its option, and with consent of the commissioner, to issue policies of related essential property insurance on insurable property to applicants;

(c) To purchase reinsurance for all or part of the risks of the association;

(d) To levy and collect regular assessments from assessable insurers;

(e) To issue bonds or incur other forms of indebtedness, including, but not limited to, loans, lines of credit or letters of credit;

(f) To establish underwriting criteria consistent with the provisions of this chapter and as approved by the commissioner;

(g) To invest and reinvest income and assets subject to the oversight of the commissioner;

(h) To enter into contractual agreements with third parties, including the Mississippi Windstorm Mitigation Coordinating Council, for the purposes of developing and implementing windstorm mitigation programs; and

(i) All other powers necessary to carry out the provisions and intent of this chapter.

**SOURCES: Laws, 1987, ch. 459, § 4; Laws, 2007, ch. 425, § 8; Laws, 2011, ch. 460, § 2, eff from and after July 1, 2011.**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Amendment Notes** — The 2011 amendment added (h); redesignated former (h) as present (i); and made a minor stylistic change.

**Cross References** — Plan of operation, see § 83-34-13.

Mississippi Winstorm Mitigation Coordinating Council, see § 83-1-201.

## § 83-34-7. Designation of temporary board of directors; expiration of terms of office; permanent board of directors; composition of board; selection and qualifications of board members; terms of office; powers.

(1) The Board of Directors of the Mississippi Insurance Underwriting Association as presently constituted shall serve as the temporary board of directors of the association. Such temporary board of directors shall prepare and submit a plan of operation in accordance with Section 83-34-13 and shall serve until the permanent board of directors shall take office in accordance with the plan of operation. The permanent board shall consist of five (5) representatives of the members to be appointed by the temporary board of directors subject to the approval of the commissioner and three (3) agents from the coast area to be appointed by the commissioner. The terms of the members of the board of directors in place before March 22, 2007, shall expire on March 22, 2007, and such persons shall cease to serve on the board and shall relinquish all power and control of the association.

(2)(a) From and after March 22, 2007, the board of directors of the association shall consist of the following:

(i) The State Treasurer;

(ii) Five (5) of the assessable insurer companies, three (3) to be appointed by the commissioner, one (1) to be appointed by the Governor, and one (1) to be appointed by the Lieutenant Governor; each such assessable insurer appointed shall designate a representative knowledgeable in the matters of the association and authorize such representative to act and vote on its behalf;

(iii) Three (3) agents with no less than ten (10) years' experience in the property and casualty industry, two (2) of whom are residents in the coast area, and one (1) of whom is not a resident of the coast area; one (1) such coast area agent to be appointed by the Governor, one (1) such coast area agent to be appointed by the Lieutenant Governor, and the noncoast area agent to be appointed by the commissioner; and

(iv) Two (2) business leaders who have been residents of the coast area for no less than ten (10) years and who have no less than ten (10) years' experience in management of a business, one (1) to be appointed by the Governor, and one (1) to be appointed by the Lieutenant Governor.

(b) Except for the State Treasurer, the board members shall serve three-year terms with each term beginning on January 1, and the initial terms shall be staggered in the following manner:

(i) The initial term for three (3) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(ii) The initial term for one (1) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2009, thereafter to be appointed for three-year terms;

(iii) The initial term for one (1) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms;

(iv) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(v) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2009, thereafter to be appointed for three-year terms;

(vi) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms;

(vii) The initial term for one (1) of the business leaders shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(viii) The initial term for one (1) of the business leaders shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms.

(3) On or before March 22, 2007, the appropriate public official shall make such appointments and request such resignations from the existing board as are appropriate to comply with this section.

(4) The board shall be staffed by as many employees as it deems necessary.

(5) The board of directors has the power to act and make binding decisions on behalf of the association on all issues.

**SOURCES: Laws, 1987, ch. 459, § 5; Laws, 2007, ch. 425, § 9, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## JUDICIAL DECISIONS

**1. Liability.**

Representatives of insurer directors of Mississippi Windstorm Underwriting Association were not entitled to summary judgment under Fed. R. Civ. P. 56 because disputed issues existed as to whether the representatives were in fact members of the board of directors under Miss. Code Ann. § 83-34-7 or whether their assumed duties made them liable to members of the association based on breach of fiduciary duty or negligence. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 245 F.R.D. 245 (S.D. Miss. 2007).

## § 83-34-9. Participation by assessable insurers in regular assessments levied by association; financial incentives and/or penalties to ensure assessable insurers write insurance in the coast area.

(1) All assessable insurers of the association shall participate in regular assessments levied by the association based upon their percentage of participation. The association may allow affiliated insurers to combine their annual net direct premiums and other data, including data that supports any incentives that may be allowed by the association, to the extent that such grouping promotes the voluntary writing of essential property insurance in the coast area. Any provisions for credits and grouping of data shall be prescribed in the plan of operation.

(2) All profits of the association shall remain as assets of the association.

(3) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in recovery of regular assessments, a nonrecoverable participation in losses incurred by the association above the amounts covered by the regular assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation. The commissioner shall approve the plan of operation as provided in Section 83-34-13.

**SOURCES: Laws, 1987, ch. 459, § 6; Laws, 2007, ch. 425, § 10, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References** — Assessment against member insurers, in the manner provided in this section, of amount by which assessment against another member is deferred, see § 83-34-11.

Applicability of this section to assessment amounts ordered deferred with respect to one member insurer and assessed against other member insurers, see § 83-34-15.

Plan of operation generally, see § 83-34-13.

Power to levy regular assessments upon occurrence of certain events, see § 83-34-10.

Deferment of assessable insurer's regular assessment, see § 83-34-12.

## § 83-34-10. Power to levy regular assessments upon occurrence of certain events; maximum total assessments.

In the event of a storm that may produce losses in excess of funds that may be immediately available to the association, or in the event that the association determines that it will otherwise have a claim deficit or any other deficit, then the association, with consent of the commissioner, shall have the power to levy regular assessments against assessable insurers based upon their percentage of participation. In any year, the annual total of regular assessments shall not exceed the greater of ten percent (10%) of the deficit or ten percent (10%) of the aggregate statewide direct written premiums for property insurance for the prior calendar year of all association assessable insurers. Regular assessments shall be paid by assessable insurers within sixty (60) days of receipt of the notice of the assessments.

**SOURCES: Laws, 2007, ch. 425, § 11, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References** — Participation by assessable insurers in regular assessments levied by association, see § 83-34-9.

Deferment of assessable insurer's regular assessment, see § 83-34-12.

## § 83-34-11. Implementation of surcharge on all property and casualty premiums; exceptions; collection of surcharges; funds collected as surcharges to be used to reimburse assessable insurers for regular assessments; reimbursement to be refunded to association under certain conditions; audit of insurers; quarterly reports.

(1) Within one hundred twenty (120) days of the levy of any regular assessments, the commissioner shall implement a surcharge on all property and casualty insurance premiums for insurance for property and activities in this state designed to recover to the association within one (1) year the amount of such regular assessment for reimbursement to assessable insurers who paid the regular assessment. "Premiums" includes premiums for policies issued by or for the association and by or for the Mississippi Residential Property Insurance Underwriting Association. "Premiums" shall not include premiums for workers' compensation coverage, premiums for medical malpractice liability coverage including medical malpractice liability coverage issued by companies created under Section 83-47-1 et seq., nor any premiums for coverage by insurance pools or plans administered by or through the State of Mississippi. Such surcharge shall be specifically identified on either the premium statements or the policy declarations pages or other appropriate policy forms as relating to the specific Mississippi Windstorm Underwriting Association regular assessment for which it was implemented. The commissioner shall name each such surcharge so that it can be uniformly identified by insurers and agents placing insurance through nonadmitted insurers.

(2) The surcharge shall be a percentage of the total policy premium, but the surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the surcharge shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(3) If at any time, the surcharge to repay regular assessments shall be insufficient, the commissioner shall increase the surcharge as necessary and appropriate. However, in no event may the aggregate total of all regular

assessments in a year exceed the maximum amounts specified in Section 83-34-10.

(4) The commissioner shall cease regular assessment surcharges as he determines appropriate funds have been collected. However, the commissioner shall endeavor to apply surcharges on a one-year basis in order to promote consistency, nondiscrimination and fairness among policyholders purchasing or renewing insurance during that year. Any collections in excess of the amounts needed shall be assets of the association for investment and other uses.

(5) Each licensed insurer issuing insurance for property and casualty risks in the state and each agent placing insurance through nonadmitted insurers, shall collect the regular assessment surcharges established by the commissioner under the authority of this section. Funds collected by such insurers and agents as regular assessment surcharges shall be collected and held in trust and shall be fully remitted to the association on a quarterly basis with forms providing appropriate information as designed by the association. Insurers and agents shall remit such funds to the association within twenty (20) days after the end of each quarter. At such time the insurers and agents shall further remit to the association all interest earned on the surcharge funds. However, assessable insurers of the association who have paid to the association the regular assessment that is the basis of the surcharge shall not be required to remit interest earned on collected surcharges from the lines of business on which their regular assessment was based.

(6) The association shall reimburse assessable insurers for regular assessments from the funds collected as regular assessment surcharges. Reimbursements shall be made to assessable insurers in the same percentages as the regular assessments were paid by assessable insurers. The association must endeavor to make reimbursements from the surcharge funds collected within sixty (60) days of the end of each quarter. Any funds collected by the association in excess of the amount necessary to reimburse assessable insurers for regular assessments shall be general funds of the association.

(7) The reimbursement to assessable insurers for regular assessments as provided in subsection (6) must be refunded to the association by any insurer that reduces its property writings in the state by more than ten percent (10%) in the five-year period beginning January 1 of the year following the regular assessment, unless such insurer is granted an exception by the commissioner after public hearing on the request for exception. The reasons for an exception by the commissioner shall include, but are not limited to, inadequate solvency to continue writing at the previous level. Refunds shall be proportionate to the point in time during the five-year period the assessable insurer drops its property writings more than ten percent (10%). Prior to receiving any reimbursement by the association, each assessable insurer must execute an agreement provided by the association agreeing to comply with the intent of this subsection.

(8) The association and the commissioner are both specifically given the power to audit licensed insurers and agents placing insurance through

nonadmitted insurers to confirm the accuracy of remittances of surcharges at the expense of the licensed insurers and agents.

(9) The association shall report quarterly to the commissioner providing all financial information for each regular assessment surcharge, including:

(a) The original amount of the regular assessment and the amount remaining not reimbursed to assessable insurers;

(b) Total surcharge funds recovered to date; and

(c) Any information requested by the commissioner.

**SOURCES: Laws, 1987, ch. 459, § 7; Laws, 2007, ch. 425, § 12, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References** — Maximum total regular assessments, see § 83-34-10.

## § 83-34-12. Deferment of assessable insurer's regular assessment; amount deferred to be assessed against other assessable insurers.

The regular assessment of an assessable insurer may, after hearing, be ordered deferred, in whole or in part, upon application by the insurer if, in the opinion of the commissioner, payment of the assessment would render the insurer insolvent or in danger of insolvency, or would otherwise leave the insurer in such a condition that further transaction of the insurer's business would be hazardous to its policyholders, creditors, assessable insurers, subscribers, stockholders or the public. If that payment of an assessment against an assessable insurer is deferred by order of the commissioner, in whole or in part, the amount by which the assessment is deferred shall be assessed against other assessable insurers in the same manner as provided in Section 83-34-9.

**SOURCES: Laws, 2007, ch. 425, § 13, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

**Cross References** — Power of association to levy regular assessments against assessable insurers, see § 83-34-10.

Participation by assessable insurers in regular assessments levied by association, see § 83-34-9.

## § 83-34-13. Plan of operation; contents; approval by commissioner; certification of approval; effective date of plan.

(1) Within forty-five (45) days after March 22, 2007, the directors of the association shall submit to the commissioner for review and approval a proposed plan of operation revised to be consistent with the provisions of

Chapter 425, Laws of 2007. The association shall maintain a plan of operation. The plan shall provide for the efficient, economical, fair and nondiscriminatory administration of the association. The plan may include methods for the assessment of all assessable insurers for deficits and expenses, the establishment of necessary facilities, management of the association, underwriting standards, procedures for determining the amounts of insurance to be provided to specific risks, time limits and procedures for processing applications for insurance, and for such other provisions as may be deemed necessary by the board to carry out the purposes of this chapter.

(2) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in recovery of regular assessments, a nonrecoverable participation in losses incurred by the association above the amounts covered by the regular assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation.

(3) The plan of operation shall provide (a) that the association shall offer a two percent (2%) deductible for loss from named storms; and (b) that the association shall also offer options for other deductibles for loss from named storms with appropriate rate reductions that shall include at least a twenty percent (20%) deductible for loss from named storms.

(4) The plan of operation shall provide that the association use actuarially appropriate geographical zones for rating and for the use of credits and penalties to encourage voluntary writing in the coast area.

(5) The commissioner shall approve the plan of operation and all amendments before they become effective. It is the obligation of the commissioner to confirm that such plan fulfills the purposes of this chapter. If the commissioner approves a proposed plan or amendment, he shall certify the approval to the directors, and the plan, or amendment thereto, shall become effective ten (10) days after such certification. If the commissioner disapproves all or any part of the proposed plan of operation, or amendment thereto, he shall return the same to the directors with a written statement giving the reasons for disapproval and any recommendations the commissioner may wish to make. Within ten (10) days thereafter, the directors may alter the plan or amendment in accordance with the commissioner's recommendation or may return a new plan to the commissioner. The commissioner shall consider the proposals and shall then promulgate and place into effect a plan of operation certifying the same to the directors of the association after approval by the board of directors. Any such plan promulgated by the commissioner shall take effect ten (10) days after certification to the directors.

(6) The commissioner may review the plan of operation at any time he deems expedient or prudent. After review of the plan, the commissioner may amend the plan after consultation with the directors of the association and upon certification to the directors of the amendment.

**SOURCES: Laws, 1987, ch. 459, § 8; Laws, 2007, ch. 425, § 14, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note —** Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Laws of 2007, ch. 425, added §§ 27-15-133, 83-34-4, 83-34-10, 83-34-12, 83-34-31, 83-34-33, 83-34-35, 83-34-37, and 83-34-39, and amended §§ 83-34-1, 83-34-3, 83-34-5, 83-34-7, 83-34-9, 83-34-11, 83-34-13 through 83-34-23, and 83-34-27.

**Cross References —** Submission of a plan of operation in accordance with this section by the temporary board of directors of the Windstorm Underwriting Association, see § 83-34-7.

"Coast area" defined, see § 83-34-1.

## § 83-34-15. Application for coverage; inspection of property; issuance of insurance; appeal of denial of application.

(1)(a) Any person having an insurable interest in insurable property is entitled to apply to the association for such coverage. Applications shall be made on behalf of the owner of the insurable interest by a licensed resident broker or agent authorized by him. Applications shall be submitted on forms prescribed by the association.

(b) The association may require an inspection of any properties after application or request for renewal and may charge a fee for such inspection.

(c) The term "insurable interest" as used in this subsection shall be deemed to include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(2) If the association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued, or issue, a policy of essential property insurance. Such coverage shall be dependent upon the timely payment and actual receipt by the association of premiums or premium installments as provided for at the time of application. Coverage limits shall be determined by the value of the insurable property at the time the policy is issued subject to maximum limits which shall be set forth under the plan of operation.

(3) If the association for any reason denies an application and refuses to issue or cause to be issued an insurance policy to any applicant, or takes no action on an application within the time prescribed in the plan of operation, such applicant may appeal to the commissioner. The commissioner or a designated member of his staff, after reviewing the facts, may direct the association to issue or cause to be issued an insurance policy to the applicant; however, no coverage shall be in effect until such time as the premium is paid and the policy issued. In carrying out his duties pursuant to this section, the commissioner may request, and the association shall provide, any information the commissioner deems necessary to a determination concerning the reasons for the denial or delay of the application.

**SOURCES: Laws, 1987, ch. 459, § 9; Laws, 2007, ch. 425, § 15, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note —** Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

### JUDICIAL DECISIONS

1. In general.
2. Under former § 83-35-15.

**1. In general.**
Servicing insurer was not entitled to a grant of summary judgment because genuine issues of material fact existed as to whether a servicing insurer was an agent for a disclosed principal, the Mississippi Windstorm Underwriting Association, and whether the insurer committed gross negligence regarding the determination of the insureds' losses. Fonte v. Audubon Ins. Co., 8 So. 3d 161 (Miss. 2009), modified and rehearing denied by 2009 Miss. LEXIS 216 (Miss. May 14, 2009).

**2. Under former § 83-35-15.**
The deposit in the mail of a premium two days prior to the expiration date of the policy was effective to renew the policy even though the premium arrived at the insurance company's office after the expiration date of the policy, since the insurance company had adopted the postal service as its agent and the premium was mailed in apt time to reach the insurance company by the due date. Mississippi Ins. Underwriting Ass'n v. Maenza, 413 So. 2d 1384 (Miss. 1982).

### RESEARCH REFERENCES

**ALR.** Causes of loss under windstorm insurance coverage. 93 A.L.R.2d 145.

Temporary fire, wind, or hail insurance pending issuance of policy. 14 A.L.R.3d 568.

What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 482-484.

44 Am. Jur. 2d, Insurance §§ 1965, 1966.

**CJS.** 45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

## § 83-34-16. Premium discount for building "fortified home."

The Mississippi Windstorm Underwriting Association shall provide a premium discount for any individual who builds a "fortified home" pursuant to the Institute for Business and Home Safety (IBHS). Licensed architects, engineers or inspectors certified by the Department of Insurance shall determine whether a dwelling meets the criteria for a "fortified home" pursuant to the Institute for Business and Home Safety. The Mississippi Windstorm Underwriting Association shall provide a premium discount for any individual who improves his residence with demonstrated mitigation measures that provide protection against damages caused by a windstorm or hurricane.

**SOURCES: Laws, 2009, ch. 537, § 2, eff from and after July 1, 2009.**

## § 83-34-17. Rates.

The rates, rating plans, rating rules, forms and endorsements applicable to the insurance written by the association shall be those approved for use of the association by the commissioner. Rates shall be nondiscriminatory as to the same class of risk.

**SOURCES: Laws, 1987, ch. 459, § 10; Laws, 2007, ch. 425, § 16, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 40-42.

## § 83-34-19. Appeals.

(1) Any assessable insurer or other licensed insurer, or agent placing insurance through a nonadmitted insurer, who may be aggrieved by an act, order, ruling or decision of the association may, within thirty (30) days after such ruling, appeal to the commissioner. Any hearings held by the commissioner pursuant to such an appeal shall be in accordance with the procedure set forth in the insurance laws of Mississippi. The commissioner is authorized to appoint a member of his staff for the purpose of hearing such appeals, and a ruling based upon such hearing shall have the same effect as if heard by the commissioner. All assessable insurers or other licensed insurers, or agents placing insurance through a nonadmitted insurer, aggrieved by any order or decision of the commissioner may appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, consistent with the insurance laws of the State of Mississippi.

(2) The association and any assessable insurer, other licensed insurer or agent placing insurance through a nonadmitted insurer that may be aggrieved by an act, order, ruling or decision of the commissioner may, within thirty (30) days after such act, order, ruling or decision, appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, consistent with the insurance laws of the State of Mississippi.

**SOURCES: Laws, 1987, ch. 459, § 11; Laws, 2007, ch. 425, § 17, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## JUDICIAL DECISIONS

**1. In general.**

Motion to dismiss based on failure to exhaust administrative remedies of Miss. Code Ann. § 83-34-19 was denied because the remedy was inadequate to resolve Mississippi Windstorm Underwriting Association members' claims regarding the amount of reinsurance, breach of fiduciary duty, and negligence in that the claims did not specifically relate to remedy; there were short, successive deadlines, a lack of objective standards of review under Miss. Code Ann. § 83-34-29, due process concerns, and the members were allegedly unable to discover facts material to exercise the remedy. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 507 F. Supp. 2d 610 (S.D. Miss. 2007).

Although a litigant was required to exhaust administrative remedies before seeking judicial review, the appellate court declined to decide the appeal on the insureds' failure to exhaust their administrative remedies because the insureds' policy had expired, and they had not submitted an application for renewal. Consequently, the insureds were not an "applicant" or an "insured" within the meaning of the Mississippi Windstorm Underwriting Association's "plan of operation" which provided for appeals by applicants or insureds. Luedke v. Audubon Ins. Co., 874 So. 2d 1029 (Miss. Ct. App. 2004).

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 482-484.

44 Am. Jur. 2d, Insurance §§ 1965, 1966.

**CJS.** 45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

## § 83-34-21. Reports of inspection made available.

All reports of inspection performed by or on behalf of the association shall be made available to the assessable insurers of the association, applicants, agents, brokers and the commissioner.

**SOURCES: Laws, 1987, ch. 459, § 12; Laws, 2007, ch. 425, § 18, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-23. Immunity from liability.

There shall be no liability on the part of the insurance commissioner or any of his staff and representatives for any action taken under and pursuant to the provisions of this chapter. There shall be no liability on the part of the association, its agents, representatives or employees, the members of the board, or any assessable insurer of the association, except for the contractual obligations of any contract of insurance and the duty to pay assessments as provided in this chapter.

**SOURCES: Laws, 1987, ch. 459, § 13; Laws, 2007, ch. 425, § 19, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-25. Annual report.

The association shall file in the office of the commissioner on or before March 1 of each year a statement which shall summarize the transactions, conditions, operations and affairs of the association during the preceding fiscal year ending December 31. Such statement shall contain such matters and information as are prescribed by the commissioner and shall be in such form as required by him. The commissioner may at any time require the association to furnish to him any additional information with respect to its transactions or any other matter which the commissioner deems to be material to assist him in evaluating the operation and experience of the association.

**SOURCES: Laws, 1987, ch. 459, § 14, eff from and after passage (approved April 14, 1987).**

## § 83-34-27. Commissioner may examine affairs of association; commissioner and association may examine data and payments of assessable insurer or insurers placing insurance through nonadmitted insurers.

The commissioner may from time to time make an examination into the affairs of the association when he deems prudent and, in undertaking such examination, may hold a public hearing. The expenses of such examination shall be borne and paid by the association. The association and the commissioner may from time to time make an examination of the data and payments of assessable insurers or other licensed insurers or agents placing insurance through nonadmitted insurers as it deems prudent. The expenses of such examination shall be borne and paid by the examined party or entity. Any person noticed for such examination may appeal the examination or the cost thereof, or both, to the commissioner.

**SOURCES: Laws, 1987, ch. 459, § 15; Laws, 2007, ch. 425, § 20, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"
**Cross References** — "Nonadmitted insurer" defined, see § 83-34-1.

## § 83-34-29. Rules and regulations.

The association is authorized to promulgate rules for the implementation of this chapter, subject to the approval of the commissioner.

**SOURCES: Laws, 1987, ch. 459, § 16, eff from and after passage (approved April 14, 1987).**

### JUDICIAL DECISIONS

**1. Relation to exhaustion of remedies.**
Motion to dismiss based on failure to exhaust administrative remedies of Miss. Code Ann. § 83-34-19 was denied because the remedy was inadequate to resolve Mississippi Windstorm Underwriting Association members' claims regarding the amount of reinsurance, breach of fiduciary duty, and negligence in that the claims did not specifically relate to remedy; there were short, successive deadlines, a lack of objective standards of review under Miss. Code Ann. § 83-34-29, due process concerns, and the members were allegedly unable to discover facts material to exercise the remedy. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 507 F. Supp. 2d 610 (S.D. Miss. 2007).

### RESEARCH REFERENCES

**ALR.** Causes of loss under windstorm insurance coverage. 93 A.L.R.2d 145.

Temporary fire, wind, or hail insurance pending issuance of policy. 14 A.L.R.3d 568.

What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

## § 83-34-31. Powers and authority of board of directors to issue bonds and enter into loans or other forms of indebtedness; rights and remedies of bondholders not to be impaired.

(1) The board of directors, subject to the approval of the commissioner, shall have the power and authority to issue bonds, and the power and authority to enter into loans, letters of credit, lines of credit, and other forms of indebtedness, as needed for operations, the purchase of reinsurance, claim losses, and incurred but not reported claims.

(2) All such bonds and loans are secured by the power and duty of the commissioner to implement surcharges against all property and casualty insurance premiums for insurance for property and activities in this state sufficient to repay the bonds or loans, or both.

(3) If any of the bonds remain unsold sixty (60) days after issuance, the commissioner shall require all assessable insurers to purchase the bonds, which purchased bonds shall be treated as admitted assets; each assessable insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the assessable insurer's current percentage of participation. An assessable insurer shall not be required to purchase the bonds to the extent that the commissioner determines that the purchase would endanger or impair the solvency of the insurer. The bonds must be in a form

approved by the commissioner. With approval of the commissioner, the association may issue bonds or incur other indebtedness to retire or consolidate bonds as appropriate. Bonds and other debt obligations issued by or on behalf of the association are not to be considered "state bonds" and shall not be an obligation of the state.

(4) The state hereby covenants with holders of bonds issued pursuant to this section that the state will not limit, alter or deny the duties and obligations of this chapter, and of the association and the commissioner as established by this chapter, necessary to fulfill the terms of any agreements with bondholders, or in any way impair the rights and remedies of such bondholders as long as any such bonds remain outstanding unless adequate provision has been made for the payment of such bonds pursuant to the documents authorizing the issuance of such bonds.

**SOURCES: Laws, 2007, ch. 425, § 21, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-33. Surcharge for excess hurricane losses on all property and casualty premiums; exempted premiums; purpose of certain surcharges to be designated and specifically identified; licensed insurers and agents to collect and remit surcharges; setting and adjustment of surcharge percentage; cessation of surcharge.

(1) When the association knows or has reason to believe that (a) it has or will incur losses from a hurricane that exceed reinsurance and other reasonably available assets of the association, such that one or more bond issues or other financing, or both, will be necessary to pay claims losses and other related expenses, or (b) the association has a deficit that cannot be reasonably resolved by income available to the association, then the association shall immediately give notice to the commissioner and request that the commissioner implement by an excess hurricane loss surcharge on all property and casualty insurance premiums for insurance for property and operations in this state designed to recover to the association the amount of all such bonds and other indebtedness resulting from the hurricane, or other deficit.

(2) At such time as the commissioner can reasonably estimate the amount of bonds or indebtedness, or both, necessitated by a hurricane event, and in no event more than ninety (90) days from the notice given by the association, the commissioner shall have the duty and the power to implement an excess hurricane loss surcharge on all property and casualty insurance premiums for insurance for property and activities in this state. "Premiums" includes premiums for policies issued by or for the association and by or for the Mississippi Residential Property Insurance Underwriting Association. "Premi-

ums" shall not include premiums for workers' compensation coverage, premiums for medical malpractice liability coverage including medical malpractice liability coverage issued by companies created under Section 83-47-1 et seq., nor any premiums for coverage by insurance pools or plans administered by or through the State of Mississippi.

(3) If the surcharge is designed to repay bonds, it shall be designated as such and all funds recovered from the surcharge shall be used for repayment of the bonds for which it was implemented, until such time as the bonds have been paid or redeemed.

(4) If the surcharge is designed to repay a specific indebtedness incurred for losses from a specific hurricane, it shall be designated as such and all funds recovered from the surcharge shall be used for repayment of the indebtedness for which it was implemented, until such time as the indebtedness has been paid or redeemed.

(5) Such surcharge shall be specifically identified on either the premium statements or the policy declarations pages or other appropriate policy forms as relating to the specific hurricane losses or bonds or indebtedness for which it was implemented. The commissioner shall name each such surcharge so that it can be uniformly identified by insurers and agents.

(6) The surcharge shall be a percentage of the total policy premium but the surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the surcharge shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(7) The commissioner shall implement an appropriate surcharge percentage sufficient to recover the amount necessary for repayment of bonds and indebtedness necessitated by a hurricane, or the resolution of other deficit, as applicable. If at any time such surcharge shall be insufficient, the commissioner shall increase the surcharge as necessary and appropriate. The commissioner shall cease surcharges as he determines appropriate funds have been collected. However, the commissioner shall endeavor to apply surcharges on a one-year basis in order to promote consistency, nondiscrimination and fairness among policyholders purchasing or renewing insurance during that year. Any collections in excess of the amounts needed shall be assets of the association for investment and other uses.

(8) Each licensed insurer issuing insurance for property and casualty risks in the state and each agent placing insurance through nonadmitted insurers, shall collect the surcharges established by the commissioner under the authority of this section. Funds collected by such licensed insurers and agents placing insurance through nonadmitted insurers as surcharges authorized by this section shall be collected and held in trust and shall be fully remitted to the association on a quarterly basis with forms providing appropriate information as designed by the association. Insurers and agents shall remit such funds to the association within twenty (20) days after the end of each quarter. At such time the insurers and agents shall further remit to the association all interest earned on the surcharge funds.

(9) The association and the commissioner are both specifically given the power to audit licensed insurers and agents placing insurance through nonadmitted insurers to confirm the accuracy of remittances of surcharges at the expense of the licensed insurers and agents.

(10) The commissioner has the duty and power to adjust the percentage of any surcharge previously established as he finds appropriate taking into consideration any relevant factors, including, but not limited to, consolidation or replacement of bonds, any additional indebtedness resulting from a hurricane, the rate of recovery, anticipated length of total recovery, and impact of other hurricanes; however, the commissioner shall not reduce the amount of assessments implemented and designated to pay or redeem bonds, or other indebtedness below the amount necessary to timely pay or redeem such bonds, or other indebtedness.

(11) When the association knows or has reason to believe that surcharges authorized by this section previously established by the commissioner will be insufficient to timely pay or redeem bonds or indebtedness, the association shall immediately give notice to the commissioner. The commissioner shall alter such surcharge as necessary to timely pay or redeem bonds or pay other indebtedness.

(12) The association shall report quarterly to the commissioner providing all financial information for each surcharge authorized by this section, including:

(a) The original and current outstanding indebtedness of all bonds and loans;

(b) Total surcharge funds recovered to date; and

(c) Any information requested by the commissioner.

(13) The commissioner may request, and the association shall provide, on an immediate basis to the commissioner any financial information or other information concerning any surcharge. This section shall not limit the reporting requirements provided by Section 83-34-25.

**SOURCES: Laws, 2007, ch. 425, § 22, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.

In order to avoid or lessen the possibility and amount of surcharges authorized by this chapter, the commissioner shall approve rates for policies issued by the association at least adequate to fund annual reinsurance above a self-insured retention of One Hundred Million Dollars ($100,000,000.00) that, combined with any readily available reserves of the association, is sufficient to cover at least the probable maximum losses from a storm expected to occur once every one hundred (100) years as predicted by a model or method approved by the commissioner for the properties insured by the association at the time the reinsurance was negotiated. The amount of reinsurance in the foregoing rate adequacy requirement shall increase every two (2) years by increasing the probable maximum loss by five (5) years, until such time as the probable maximum loss insured is for a storm expected to occur every one hundred fifty (150) years. The commissioner may approve rates in excess of the minimums required by this section as consistent with his duties and the insurance laws of the State of Mississippi.

**SOURCES: Laws, 2007, ch. 425, § 23, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note —** Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-37. Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund created; purpose; use of funds; reports.

(1)(a) There is created in the State Treasury a special fund to be designated as the "Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund." The fund shall consist of monies deposited therein as provided under Section 83-34-39, monies appropriated by act of the Legislature and monies from any other source designated for deposit into such fund. Unexpended amounts remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund, and any interest earned or investment earnings on amounts in the fund shall be deposited to the credit of the fund; however, any monies in excess of Fifty Million Dollars ($50,000,000.00) remaining in the fund at the end of a fiscal year that have not been appropriated shall lapse into the State General Fund.

(b) Monies in the special fund may be used by the Department of Insurance, upon appropriation by the Legislature, only for the purpose of assisting the Mississippi Windstorm Underwriting Association in defraying expenses and costs for reinsurance under Section 83-34-1 et seq. The association may use any such funds received from the Department of Insurance for the sole purpose of defraying expenses and costs for reinsurance. Monies in the fund used for the purposes described in this paragraph (b) shall be in addition to other funds available from any other source for such purposes.

(c) Monies in the special fund may not be used, expended or transferred for any other purpose except upon amendment to this section by a bill enacted by the Legislature with a vote of not less than two-thirds (⅔) of the members of each house present and voting.

(2)(a) The Commissioner of Insurance shall file a report with the Joint Legislative Budget Committee not later than September 1 of each year, recommending the amount of assistance, if any, needed by the Mississippi Windstorm Underwriting Association for reinsurance expenses and costs. The Commissioner of Insurance also shall provide a copy of the report to the Attorney General and the Executive Director of the Mississippi Development Authority.

(b) The Mississippi Windstorm Underwriting Association shall prepare and file detailed reports with the Clerk of the House of Representatives, Secretary of the Senate, Commissioner of Insurance, Attorney General and Executive Director of the Mississippi Development Authority regarding the receipt and expenditure of monies by the association under this section.

**SOURCES: Laws, 2007, ch. 425, § 2, eff from and after passage (approved Mar. 22, 2007.)**

**Editor's Note** — Section 83-34-39, referenced in (1)(a), was repealed by its own terms, effective from and after July 1, 2010.

Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

## § 83-34-39. Repealed.

Repealed by its own terms, eff from and after July 1, 2010.

[Laws, 2007, ch. 425, § 3, eff from and after passage (approved March 22, 2007).]

**Editor's Note** — Former § 83-34-39 related to the deposit of monies into Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund.

# CHAPTER 35

## Underwriting Association [Repealed]

### §§ 83-35-1 through 83-35-31. Repealed.

Repealed by Laws, 1987, ch. 459, § 18, eff from and after December 31, 1988.

§ 83-35-1. [Codes, 1942, § 5234-101; Laws, 1970, ch 451, § 1; Laws, 1971, ch. 507, § 1; Laws, 1975, ch. 390, § 1; Laws, 1980, ch 364, § 1]

§ 83-35-3. [Codes, 1942, § 5234-102; Laws, 1970, ch. 451, § 2; Laws, 1971, ch. 507, § 2; Laws, 1974, ch. 316; Laws, 1975, ch. 390, § 2; Laws, 1980, ch. 364, § 2; Laws, 1987, ch. 422, § 52]

§ 83-35-5 through § 83-35-11. [Codes, 1942, §§ 5234-103 to 5234-106; Laws, 1970, ch. 451, §§ 3-6; Laws, 1971, ch 507, §§ 3-6; Laws, 1975, ch. 390, §§ 3-6; Laws, 1980, ch. 364, §§ 3-6]

§ 83-35-13. [Codes, 1942, § 5234-107; Laws; 1970, ch 451, § 7; Laws, 1971, ch. 507, § 7; Laws, 1975, ch. 390, § 7; Laws, 1980, ch. 364, § 7; Laws, 1987, ch. 422, § 53]

§ 83-35-15. [Codes, 1942, § 5234-108; Laws; 1970, ch 451, § 8; Laws, 1971, ch. 507, § 8; Laws, 1975, ch. 390, § 8; Laws, 1980, ch. 364, § 8; Laws, 1987, ch. 459, § 17]

§ 83-35-17 through § 83-35-31. [Codes, 1942, § 5234-109 to 5234-116; Laws, 1970, ch 451, §§ 9-16; Laws, 1971, ch. 507, §§ 9-16; Laws, 1975, ch. 390, §§ 9-16; Laws, 1980, ch. 364, § 9-16]

**Editor's Note** — Former §§ 83-35-1 thru 83-35-31 contained provisions applicable to fire and extended coverage insurance in the coast area of Mississippi and educational properties throughout the State of Mississippi. For current fire insurance provisions, see §§ 83-13-1 et seq.

### § 83-35-33. Repealed.

Repealed by Laws 1985, ch. 528, § 17, eff from and after July 1, 1985.

[Codes, 1942, § 5834-119; Laws, 1971, ch. 507, § 19; Laws, 1975, ch. 390, § 17; Laws, 1980, ch. 364, § 17]

**Editor's Note** — Former § 83-35-33 provided for the repeal of §§ 83-35-1 through 83-35-31 on July 1, 1985.

# CHAPTER 36

## Joint Underwriting Association for Medical Malpractice Insurance

| Sec. | |
|---|---|
| 83-36-1 through 83-36-27. Repealed. | |
| 83-36-29. | Repeal of Sections 83-36-1 through 83-36-27. |
| 83-36-31. | Authority of commissioner to close accounts established under this chapter; disposition of funds; release of liability of fund trustees. |

### §§ 83-36-1 through 83-36-27. Repealed.

Repealed by Laws, 1997, ch. 406, § 15 [§ 83-36-29], eff on July 1, 1998.

§ 83-36-1. [Laws, 1976, ch. 471, § 1; Laws, 1989, ch. 356, § 1; reenacted without change, Laws, 1997, ch. 406, § 1, eff from and after July 1, 1997]

§ 83-36-3. [Laws, 1976, ch. 471, § 2; Laws, 1987, ch. 472, § 1; Laws, 1989, ch. 356, § 2; reenacted without change, Laws, 1992, ch. 559, § 1; reenacted without change, Laws, 1997, ch. 406, § 2, eff from and after July 1, 1997]

§ 83-36-5. [Laws, 1976, ch. 471, § 3; Laws, 1987, ch. 472, § 2; Laws, 1989, ch. 356, § 3; reenacted without change, Laws, 1992, ch. 559, § 2; Laws, 1994, ch. 318, § 1; reenacted without change, Laws, 1997, ch. 406, § 3, eff from and after July 1, 1997]

§ 83-36-7. [Laws, 1976, ch. 471, § 4; Laws, 1987, ch. 472, § 3; Laws, 1989, ch. 356, § 4; reenacted without change, Laws, 1992, ch. 559, § 3; reenacted without change, Laws, 1997, ch. 406, § 4, eff from and after July 1, 1997]

§ 83-36-9. [Laws, 1976, ch. 471, § 5; Laws, 1987, ch. 472, § 4; Laws, 1989, ch. 356, § 5; reenacted without change, Laws, 1992, ch. 559, § 4; reenacted without change, Laws, 1997, ch. 406, § 5, eff from and after July 1, 1997]

§ 83-36-11. [Laws, 1976, ch. 471, § 6; Laws, 1987, ch. 472, § 5; reenacted without change, Laws, 1992, ch. 559, § 5; reenacted without change, Laws, 1997, ch. 406, § 6, eff from and after July 1, 1997]

§ 83-36-13. [Laws, 1976, ch. 471, § 7; Laws, 1987, ch. 472, § 6; reenacted without change, Laws, 1992, ch. 559, § 6; reenacted without change, Laws, 1997, ch. 406, § 7, eff from and after July 1, 1997]

§ 83-36-15. [Laws, 1976, ch. 471, § 8; reenacted without change, Laws, 1997, ch. 406, § 8, eff from and after July 1, 1997]

§ 83-36-17. [Laws, 1976, ch. 471, § 9; Laws, 1987, ch. 472, § 7; reenacted without change, Laws, 1992, ch. 559, § 7; reenacted without change, Laws, 1997, ch. 406, § 9, eff from and after July 1, 1997]

§ 83-36-19. [Laws, 1976, ch. 471, § 10; Laws, 1987, ch. 472, § 8; reenacted without change, Laws, 1992, ch. 559, § 8; reenacted without change, Laws, 1997, ch. 406, § 10, eff from and after July 1, 1997]

§ 83-36-21. [Laws, 1976, ch. 471, § 11; Laws, 1987, ch. 472, § 9; reenacted without change, Laws, 1992, ch. 559, § 9; reenacted without change, Laws, 1997, ch. 406, § 11, eff from and after July 1, 1997]

§ 83-36-23. [Laws, 1976, ch. 471, § 12; Laws, 1987, ch. 472, § 10; reenacted without change, Laws, 1992, ch. 559, § 10; reenacted without change, Laws, 1997, ch. 406, § 12, eff from and after July 1, 1997]

§ 83-36-25. [Laws, 1976, ch. 471, § 13; Laws, 1987, ch. 472, § 11; reenacted without change, Laws, 1992, ch. 559, § 11; reenacted without change, Laws, 1997, ch. 406, § 13, eff from and after July 1, 1997]

§ 83-36-27. [Laws, 1976, ch. 471, § 14; reenacted without change, Laws, 1997, ch. 406, § 14, eff from and after July 1, 1997]

**Editor's Note** — Former § 83-36-1 related to the legislative purpose of provisions regarding the joint underwriting association for medical malpractice insurance.

Former § 83-36-3 related to definitions for provisions regarding the joint underwriting association for medical malpractice insurance.

Former § 83-36-5 related to the creation and conditions for the joint underwriting association for medical malpractice insurance.

Former § 83-36-7 related to directors of the joint underwriting association for medical malpractice insurance.

Former § 83-36-9 related to plans for operation and legislative review of the joint underwriting association for medical malpractice insurance.

Former § 83-36-11 related to rates and premiums for the joint underwriting association for medical malpractice insurance.

Former § 83-36-13 related to the stabilization reserve fund and directors.

Former § 83-36-15 related to applications for coverage and issuance of policies concerning the joint underwriting association for medical malpractice insurance.

Former § 83-36-17 related to member participation in the joint underwriting association for medical malpractice insurance.

Former § 83-36-19 related to appeals of matters concerning the joint underwriting association for medical malpractice insurance.

Former § 83-36-21 related to the annual report of the joint underwriting association for medical malpractice insurance.

Former § 83-36-23 related to an annual examination of the affairs of the joint underwriting association for medical malpractice insurance.

Former § 83-36-25 related to immunity concerning certain matters handled by the joint underwriting association for medical malpractice insurance.

Former § 83-36-27 related to the rights of public officers serving as directors of the stabilization reserve fund.

**Cross References** — Medical Malpractice Insurance Availability Act, see §§ 83-48-1 et seq.

## § 83-36-29. Repeal of Sections 83-36-1 through 83-36-27.

Sections 83-36-1 through 83-36-27 shall stand repealed on July 1, 1998.

**SOURCES: Laws, 1992, ch. 559, § 13(1); Laws, 1997, ch. 406, § 15, eff from and after July 1, 1997.**

**Cross References** — Medical Malpractice Insurance Availability Act, see §§ 83-48-1 et seq.

## § 83-36-31. Authority of commissioner to close accounts established under this chapter; disposition of funds; release of liability of fund trustees.

(1) Upon thirty (30) days' notice to interested parties, the Commissioner may close any accounts established under this chapter. Any funds in the accounts or any other funds collected and received by the administrator or

trustee of the temporary joint underwriting association established under Section 83-36-5 shall be paid to the State Treasurer for deposit in the State General Fund.

(2) Upon accounting to the Commissioner and disbursement of funds as provided in subsection (1) of this section, all past and present directors of the association shall be relieved from any liability concerning the funds and other provisions of this chapter.

**SOURCES: Laws, 1994, ch. 318, § 2, eff from and after passage (approved March 10, 1994).**

**Editor's Note** — Section 83-36-5 referred to in (1), was repealed by Laws of 1997, ch. 406, § 15, eff on July 1, 1998.

# CHAPTER 37

## Burial Associations

Sec.
83-37-1. Unlawful unless organized under this chapter.
83-37-3. Method of organization.
83-37-5. Articles of incorporation; restriction on formation of new companies.
83-37-7. Foreign corporations admitted.
83-37-9. Corporate contract forms and rate schedules to be filed.
83-37-11. Classes of burial associations.
83-37-12. Buyer's guide.
83-37-13. Standard contract provisions.
83-37-15. Conditions for certain contracts.
83-37-17. Premium taxes.
83-37-19. Annual reports.
83-37-21. Privilege tax.
83-37-23. Cancellation of license.
83-37-25. Fiscal examinations.
83-37-27. Licenses issued as of March 1st; term.
83-37-29. Penalties.
83-37-31. Receivership.
83-37-33. Scope of this chapter.
83-37-35. Promulgation of rules and regulations regulating sale and solicitation of burial contracts; cease and desist orders.

### § 83-37-1. Unlawful unless organized under this chapter.

It shall be unlawful for any person, firm, association, church burial club or association, or corporation to engage in the business of a burial association or to make contracts in advance of death to bury or to pay the funeral expenses of any person or persons or to make contracts in advance of death to pay any person or persons a sum of money in lieu of funeral expenses except under the conditions hereafter set out.

If a church burial club or association enters into any kind of informal agreement or understanding, written or otherwise, to pay for funerals of its members and if it collects premiums, contributions, or any other funds therefor in competition with other burial associations, it shall come under the above definition of a burial association and be subject to all the provisions of this chapter. The secretary, treasurer, secretary-treasurer, or any other officer, by whatever name called, who handles the funds for the purposes set forth in this section shall be required to file annual reports, as required by Section 83-37-19, Mississippi Code of 1972; and failure to file such annual reports or knowingly making any false statement in the reports required shall be punished as provided by Section 83-37-29, Mississippi Code of 1972.

**SOURCES: Codes, 1930, § 3990; 1942, §§ 5592, 5592.5; Laws, 1928, ch. 197; Laws, 1956, ch. 332, §§ 1, 2.**

**Cross References** — Maintenance of cemetery by trust fund, see § 41-43-3.
Trust business charter exemption, see § 81-27-1.102

Burial associations regulated under this chapter are excluded from definition of "insurer" as provided in § 83-5-1, see § 83-6-1.

Exclusion of burial association from requirement of surplus in minimum amount, see § 83-19-77.

### RESEARCH REFERENCES

**ALR.** Validity of statutes regulating pre-need contracts for sale or furnishing of burial services and merchandise. 68 A.L.R.2d 1251.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 12.

**CJS.** 44 C.J.S., Insurance § 71.

## § 83-37-3. Method of organization.

Any person, firm, or association desiring to engage in the business above set out shall apply to the insurance commissioner of the State of Mississippi for a permit or license; file with the said commissioner a copy or statement in writing of the plan on which he or they propose to operate such business, the forms of all such contracts as he or they propose to make and enter into, the residence and post-office address of any such person, firm, or association, the rates to be charged, which rates shall in all cases be subject to the approval of the insurance commissioner except in cases where burial associations operate under a mutual benefit plan, and the names of all persons interested in such business other than members with whom contracts are made to pay burial expenses; and shall secure from the insurance commissioner of this state annually a license to engage in said business before engaging therein. Any corporation desiring to engage in the business above set out shall comply with all of the conditions of this section and, furthermore, be incorporated or admitted to do business as hereinafter provided.

**SOURCES: Codes, 1930, § 3991; 1942, § 5593; Laws, 1928, ch. 197; Laws, 1932, ch. 290.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

**CJS.** 46 C.J.S., Insurance § 1973.

## § 83-37-5. Articles of incorporation; restriction on formation of new companies.

(1) Until July 1, 1996, companies may be formed and organized to engage in the business herein mentioned with a capital stock of not less than Five Thousand Dollars ($5,000.00). The proposed incorporators, a majority of whom must be residents of the state, and not less than three (3), shall subscribe articles of incorporation in which shall be stated:

(a) The proposed corporate name of the company, which shall not so closely resemble the name of any corporation already transacting business in this state as to mislead the public or lead to confusion;

(b) The purpose for which it was formed and the business plan or principle of the operation of its business;

(c) The names, residences and official titles of all the officers who are to have and exercise the general control and management of the affairs and the funds of the corporation;

(d) The domicile of the proposed corporation;

(e) The amount of the capital stock.

The charter or articles of incorporation shall be approved by the Insurance Commissioner, and a certificate of approval shall be executed by the commissioner. The charter as thus approved shall be recorded in the Office of the Insurance Commissioner of this state and shall also be recorded in the Office of the Secretary of State.

(2) After July 1, 1996, no new companies may be formed and organized to engage in the business mentioned herein.

(3) No companies formed and organized to engage in the business herein mentioned may be sold, transferred or exchanged without prior approval of the Commissioner of Insurance. Before approval by the commissioner is granted, the commissioner shall verify and require that the company has an enforceable agreement with a duly licensed funeral service establishment pursuant to Section 73-11-55 to service the policies, contracts or certificates of the company; however, there shall be no reduction in benefits paid under the policy if the policyholder is affected by a merger or assumption and elects not to use the funeral home so designated under the assumption agreement.

**SOURCES: Codes, 1930, § 3992; 1942, § 5594; Laws, 1928, ch. 197; Laws, 1996, ch. 357, § 1, eff from and after passage (approved March 18, 1996).**

**Editor's Note —** Laws of 1996, ch. 357, § 4, provides as follows:

"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act of [March 18, 1996] all the provisions of this act."

**Cross References —** Classes of burial associations, see § 83-37-11.

### ATTORNEY GENERAL OPINIONS

A burial association whose license has been revoked by the Commissioner of Insurance can reapply for a new license. Dale, Mar. 19, 2004, A.G. Op. 04-0090.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 67 et seq.

**CJS.** 44 C.J.S., Insurance §§ 105-115.

## § 83-37-7. Foreign corporations admitted.

Any foreign corporation organized to engage in the business of a burial association may be admitted to do business in this state on the following conditions:

(a) It shall deposit with the Commissioner of Insurance a certified copy of its charter and a statement of its financial condition and business in such form and detail as he may require, signed and sworn to by its president and secretary or other proper officer, and shall pay for the filing of such statement the sum of Twenty Dollars ($20.00).

(b) It shall satisfy the commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact and that it has a fully paid up and unimpaired capital of not less than Five Thousand Dollars ($5,000.00). After July 1, 1996, no foreign corporation organized to engage in the business of a burial association or unincorporated Class A burial association shall be admitted to do business in this state.

(c) It shall, by duly executed instrument filed in his office, constitute and appoint the Commissioner of Insurance and his successor its true and lawful attorney upon whom all process in any action or legal proceeding against it may be served, and therein shall agree that any process against it which may be served upon its attorney shall be of the same force and validity as if served on the company; and the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state. The service of such process shall be made by leaving a copy of the same in the hands or office of the commissioner. Copies of such instrument certified by the commissioner shall be deemed sufficient evidence thereof, and service upon such attorney shall be deemed sufficient service upon the principal.

(d) It shall appoint as its agent or agents in this state some resident or residents thereof other than the commissioner, such appointment to be made in writing, signed by the president and secretary or manager or general agent, and filed in the office of the commissioner, authorizing the agent to acknowledge service of process for and on behalf of the company, and consenting that service of process on the agent shall be as valid as if served upon the company, according to the laws of this state, and waiving all claim of error by reason of such service.

(e) It shall obtain from the commissioner a certificate that it has complied with the laws of the state and is authorized to make contracts authorized hereunder.

**SOURCES: Codes, 1930, § 3993; 1942, § 5595; Laws, 1928, ch. 197; Laws, 1996, ch. 357, § 2, eff from and after passage (approved March 18, 1996).**

**Editor's Note —** Laws of 1996, ch. 357, § 4, provides as follows:

"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act [March 18, 1996] of all the provisions of this act."

**Cross References —** Service of process upon agents of trustees or attorneys in fact, see § 13-3-41.

Requirements for admission of foreign insurance companies, see §§ 83-21-1, 83-21-3.

Classes of burial associations, see § 83-37-11.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 85.

**CJS.** 44 C.J.S., Insurance §§ 129, 130.

## § 83-37-9. Corporate contract forms and rate schedules to be filed.

Any domestic or foreign corporation engaging in the business set forth herein shall also file with the insurance commissioner sample forms of all such contracts as it proposes to make and enter into and the rates to be charged, and shall secure from the insurance commissioner of this state annually a license to engage in said business before engaging therein, in like manner as if such corporation were a person, firm, or association as hereinabove set forth.

**SOURCES: Codes, 1930, § 3994; 1942, § 5596; Laws, 1928, ch. 197.**

JUDICIAL DECISIONS

**1. In general.**

Insurance commissioner could not cancel license on ground of refusal to accept new rate and contract form adopted by commissioner, and could not enjoin insurer's continuing in business. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529 (1937).

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 68, 73.

**CJS.** 44 C.J.S., Insurance §§ 81-83, 392.

## § 83-37-11. Classes of burial associations.

Before engaging in said business, any such person, firm, association, or corporation, both foreign and domestic, shall deposit with the Treasurer of the State of Mississippi such securities as may be approved by the Commissioner of Insurance, consisting of certificates of deposit or bonds of the United States, of the State of Mississippi, or of any county, municipality, levee district, or road district in this state. The securities so deposited shall be not less than par value of Five Hundred Dollars ($500.00) for each One Hundred Twenty-five Thousand Dollars ($125,000.00), or fraction thereof, of face value and in-force certificates.

Any such person, firm, association, or corporation organized under this section may issue contracts or burial certificates in amounts not to exceed One Hundred Fifty Dollars ($150.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than One Thousand Dollars ($1,000.00) par value. Said person, firm, association, or corporation organized under this section may also issue contracts or burial certificates in amounts not to exceed Three Hundred Dollars ($300.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than Two Thousand Dollars ($2,000.00) par value. Said person, firm, association, or corporation organized under this section may also issue contracts or burial certificates in amounts not to exceed Four Hundred Fifty Dollars ($450.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than Three Thousand Dollars ($3,000.00) par value.

Any such person, firm, association, or corporation who prior hereto had on deposit with the Treasurer of the State of Mississippi the maximum amount of securities heretofore required shall not be required to deposit additional securities except on the net increase in liability of in-force certificates issued after January 1, 1974.

No individual benefit shall exceed the sum of Four Hundred Fifty Dollars ($450.00) unless said benefit in excess of Four Hundred Fifty Dollars ($450.00) is written on a schedule of rates approved by the State Commissioner of Insurance, and unless said contract specifically stipulates that anyone insured thereunder may receive in cash at his or her option the face value thereof; and with the further provision that any and all burial certificates in excess of Four Hundred Fifty Dollars ($450.00) shall come under and be subject to all the qualifications and all provisions of law governing life insurance contracts and policies in the State of Mississippi.

All contracts issued by a person, firm, association, or corporation of any of the above classifications will be issued in amounts of One Hundred Fifty Dollars ($150.00), Three Hundred Dollars ($300.00), or Four Hundred Fifty Dollars ($450.00) only. The provisions of this subsection shall not apply to funeral benefit certificates already in force in excess of Four Hundred Fifty Dollars ($450.00). No person, firm, association, or corporation shall write or issue a paid-up certificate.

A surety bond made by some company authorized to do business in Mississippi for an amount equal to twice the amount of securities required above may be filed with the Treasurer, after approval by the insurance department, in lieu of the other securities above referred to.

**SOURCES: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452; Laws, 1973, ch. 435, § 1; Laws, 1987, ch. 330; Laws, 1998, ch. 323, § 5, eff from and after July 1, 1998.**

**Cross References —** Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

Burial associations operating under the provisions of this section not required to pay premium taxes, see § 83-37-17.

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 72.

**CJS.** 44 C.J.S., Insurance §§ 121-123, 132, 133.

## § 83-37-12. Buyer's guide.

Each policy or contract or certificate issued under Section 83-37-11 shall have attached a buyer's guide which shall be developed by the Commissioner of Insurance and shall contain a definition of the burial contract, its provisions, its benefits and notice of the freedom of choice as provided by Section 83-37-13.

**SOURCES: Laws, 1996, ch. 357, § 3, eff from and after passage (approved March 18, 1996).**

**Editor's Note** — Laws of 1996, ch. 357, § 4, provides as follows:

"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act [March 18, 1996] of all the provisions of this act."

**Cross References** — Classes of burial associations, see § 83-37-11.

## § 83-37-13. Standard contract provisions.

Contracts written under the provisions of Section 83-37-11 must first be approved by the commissioner of insurance and must be substantially in the following form and language; any variation thereof shall in no manner be less favorable to the insured than the form and language prescribed herein.

All policies written under authority of Section 83-37-11 shall contain the standard provisions hereinafter enumerated:

### "STANDARD PROVISIONS"

"(1) The association will not be responsible for casket or any other funeral supplies or expenses contracted for by anyone unless authorized by the association, subject to minimum cash settlement hereinafter provided.

"(2) When this policy has been maintained in force for not less than two (2) consecutive months, there will be a grace period of thirty (30) days for the payment of any subsequent premium; and during such period of grace, the funeral benefit provided herein shall continue in force, provided all other conditions and stipulations herein contained shall have been complied with by such member or members.

"(3) This contract shall lapse, and the association shall not be liable for any benefits hereunder, when any premium payment on same is more than thirty (30) days in arrears; and in such event all premiums paid hereon shall be forfeited to the association.

"(4) If the contract is allowed to lapse, it may be reinstated by furnishing the association with satisfactory evidence that all members named hereon are in good health, and by the payment of the premiums required by the association, provided the policy is not over six (6) months in arrears. Acceptance of premium as of date of lapse shall reinstate the contract as of date premium is applied on lapse period.

"(5) No agent has the power on behalf of the association to modify this contract or to extend the time for payment of premium, the entire contract being that contained herein, together with the application thereof.

"(6) The association reserves the right to investigate within one (1) year from date of application all statements made in the application as to age or condition of health, and should any of the statements made therein be found to be false, the association's liability shall be limited to the return of all premiums paid hereon, and the policyholder shall forfeit all rights to the funeral benefits. All applicants must be in good health when this contract is delivered.

"(7) This contract shall be incontestable after one (1) year, except for nonpayment of premiums.

"(8) If death and/or burial occurs more than fifty (50) miles from any location of the funeral home named herein and should the beneficiary therefore deem it impractical for the association to service this contract, the association shall pay in cash to the member not less than fifty percent (50%) of the face value of the certificate to which the member is entitled or the full return of the premium paid by the member, not to exceed three-fourths percent (¾%) of the face value of the certificate, whichever amount is larger. Provided, however, if premium rates of not less than ten percent (10%) in excess of the rates described herein are requested by the association and approved by the commissioner, the standard provisions contained in this paragraph may provide for a cash settlement up to one hundred percent (100%) of the face value of the contract. If death and/or burial occurs within fifty (50) miles of any location of the funeral home named herein, and the member desires to use a funeral home other than the funeral home named in this contract, the association's liability shall be the full return of the premium paid by the member not to exceed the face value of the certificate.

"(9) There shall be no liability to any person or persons insured hereunder if death should occur through self-destruction or suicide, whether sane or insane, within one (1) year from date of issuance of this contract, or within one (1) year from the date of any reinstatement. In the event of death by suicide or self-destruction, no return of premium shall be due under this contract."

**SOURCES: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452; Laws, 1973, ch. 435, § 1, eff from and after January 1, 1974.**

### RESEARCH REFERENCES

**ALR.** Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services. 67 A.L.R.4th 36.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 68, 70.

**CJS.** 44 C.J.S., Insurance §§ 388-390.

## § 83-37-15. Conditions for certain contracts.

A burial association may enter into burial insurance contracts with citizens of this state in a face amount of not less than Two Hundred Fifty Dollars ($250.00) nor more than Five Hundred Dollars ($500.00) for the funeral of any one person to be paid by any such burial association, subject to strict compliance with the following requirements as an absolute condition precedent to any such policy or contract being written or in force in this state:

(a) Such a burial association must be incorporated under the provisions of this chapter, and at least Twenty-five Thousand Dollars ($25,000.00) in capital stock paid up before the commencement of business by any such corporation may be authorized.

(b) Only contracts with uniform benefits may be written, which must be first approved by the commissioner of insurance, and such contracts may be written on a basis of payment of premiums for life or, alternatively, to be paid up in not less than fifteen (15) years after date of issuance. Contract benefits shall be limited to applying the face amount of the contract toward the retailed value of funeral merchandise and service; however, such contracts may provide for cash settlement benefits.

(c) The commissioner of insurance shall require compliance with minimum premium rates governing the payment of premiums on burial insurance contracts issued under the alternative plans provided in subsection (b) of this section, and any such corporation willfully collecting rates less than those so prescribed shall have its license cancelled and revoked in accordance with the provisions of this chapter. For continuing to do business thereafter, such corporation shall be enjoined therefrom in a court of competent jurisdiction.

(d) The commissioner of insurance shall promulgate such rules and regulations as may be necessary or advisable in order to carry out the provisions of Sections 83-37-11 through 83-37-17 insofar as the same shall not conflict herewith, and shall make examinations as required of domestic life insurance companies.

(e) No corporation shall write or issue a paid-up certificate except as provided in the cited sections.

(f) Securities shall be deposited with the state treasurer equal to one half (½) of the capital stock of such companies and associations, and securities covering reserve liabilities shall likewise be deposited with the state treasurer in the amounts and manner as is now required of domestic life insurance companies.

**SOURCES: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452, eff from and after Jan. 1, 1963.**

**Cross References —** Burial associations incorporated under the provisions of this section are required to pay annual premium taxes, see § 83-37-17.

## RESEARCH REFERENCES

**ALR.** Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services. 67 A.L.R.4th 36.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 68, 70.

**CJS.** 44 C.J.S., Insurance §§ 388-390.

## § 83-37-17. Premium taxes.

(1) Those burial associations operating under the provisions of Section 83-37-11 shall not be required to pay any premium taxes.

(2) Those burial associations incorporated under the provisions of Section 83-37-15 shall be required to pay premium taxes as follows:

(a) Such foreign burial insurance companies and associations of every kind and description writing burial insurance contracts under the provisions of Section 83-37-15 shall be required to pay an annual premium tax of three percent (3%) of the gross amount of premium receipts received from and on burial insurance contracts written in or covering risks located in this state.

(b) Such domestic burial insurance companies and associations of every kind and description writing burial insurance contracts under the provisions of Section 83-37-15 shall be required to pay an annual premium tax of one half (½) of the amount hereinabove levied upon foreign burial insurance companies and associations.

**SOURCES: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 2; Laws, 1962, ch. 452, eff from and after Jan. 1, 1963.**

### RESEARCH REFERENCES

**CJS.** 44 C.J.S., Insurance §§ 118-120, 131, 132.

## § 83-37-19. Annual reports.

All such persons, firms, associations, or corporations shall, annually before the fifteenth day of February of each year, in accordance with the requirements of a form prepared and furnished by the commissioner of insurance for that purpose and in such detail as the commissioner shall prescribe, file with the commissioner a sworn statement of its business during the year previous, ending with December 31, showing the number of contracts in force, the number of contracts matured and unpaid, the amount of liability in force on said contracts at the end of the year, the business standing and the financial conditions of said persons, firms, associations, or corporations, and such other information as may be required by the commissioner of insurance.

**SOURCES: Codes, 1930, § 3996; 1942, § 5598; Laws, 1928, ch. 197; Laws, 1932, ch. 290.**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the last sentence of the section. The word "corporations" has been substituted for "corporation." The Joint Committee ratified the correction at its July 8, 2004, meeting.

**Cross References** — Annual statement of insurance companies, see § 83-5-55.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance §§ 96, 128.

## § 83-37-21. Privilege tax.

When the above and foregoing provisions have been complied with by any person, firm, association or corporation, the insurance commissioner shall issue a license to such person, firm, association or corporation upon the payment to him of a privilege tax to engage in such business, according to the following schedule, to-wit:

| | |
|---|---|
| Any person, firm, association or corporation beginning the business or having not exceeding five hundred (500) contracts | $ 50.00 |
| Same, where contracts exceed five hundred (500) but do not exceed one thousand (1,000) | 100.00 |
| Same, where contracts exceed one thousand (1,000) but do not exceed fifteen hundred (1500) | 150.00 |
| Same, where contracts exceed fifteen hundred (1500) but do not exceed two thousand (2,000) | 200.00 |
| Same, where contracts exceed two thousand (2,000) | 250.00 |

and the payment of said license shall exempt such person, firm, association, or corporation from any other privilege tax on account of said business. Provided, however, that nothing in this chapter shall exempt any such person, firm, association or corporation from the payment of any tax now imposed by law for conducting an undertaker's business or selling coffins. Every agent of any corporation organized or admitted to do business hereunder shall be required to obtain from the Commissioner of Insurance a perpetual agent certificate as prescribed in Sections 83-5-73 and 83-17-5, Mississippi Code of 1972, under the seal of his office showing that the company for which he or she is agent is licensed to do business in this state and that he or she is an agent of said company and duly authorized to do business for it. Every such agent on demand shall exhibit the said certificate to the person from whom he or she shall solicit contracts, and every such agent shall annually pay a privilege tax of Five Dollars ($5.00). The insurance commissioner may issue a duplicate certificate in case of loss or destruction of the original certificate and charge therefor a fee of Five Dollars ($5.00), and the insurance commissioner shall have the right to pass upon the qualifications of any such agent before issuing to him or her a license, and for good cause shall have the right to cancel such license.

Any person, firm, association or corporation liable for the privilege tax imposed herein who shall fail to procure the license therefor before beginning the business for which such privilege tax is required, or who shall fail to renew, during the month in which it is due, the license on said business for which a privilege license has theretofore been issued, shall, in each or either instance, be liable for the amount of the tax required for such business and fifty percent (50%) thereof. It is hereby made the duty of the insurance commissioner to collect the said tax and penalty, and the commissioner, or his duly authorized representative, may make immediate demand upon such person, firm, association or corporation for the payment of such tax and penalty, and proceed to collect the same as is provided by law for the collection of other privilege licenses, penalties and damages.

**SOURCES: Codes, 1930, § 3997; 1942, § 5599; Laws, 1928, ch. 197; Laws, 1946, ch. 359, § 1; Laws, 1990, ch. 355, § 3, eff from and after July 1, 1990.**

**Cross References —** Corporation franchise taxes, see §§ 27-13-1 et seq.
Privilege taxes on insurance agents, see § 27-15-87.
Privilege taxes on insurance companies, see §§ 27-15-103 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 67, 75.

**CJS.** 44 C.J.S., Insurance §§ 118-120, 131, 132, 138.

## § 83-37-23. Cancellation of license.

The failure of any person, firm, association, or corporation to promptly pay or fulfill any contract in force at the time of maturity, when legally determined that the contract was in force, the failure to pay promptly when due the examination fee required, the failure to pay the license fee, privilege license when due, or penalties when assessed, the failure to fulfill any contract when services are performed by another person, firm, association, or corporation with whom the deceased or his legal representative had contracted, or the failure to adhere to the approved policy form, or to collect and retain the filed and approved rate for premium as filed in the office of the commissioner of insurance, each and all shall be grounds for the cancellation by the commissioner of insurance of its license to do business in this state.

Procedure for revocation of license under the above offenses shall be the same procedure as provided in the case of insurance agents engaging in the business of life, accident, and health insurance.

**SOURCES: Codes, 1930, § 3998; 1942, § 5600; Laws, 1928, ch. 197; Laws, 1954, ch. 311; Laws, 1962, ch. 453, §§ 1, 2, eff from and after passage (approved April 30, 1962).**

### JUDICIAL DECISIONS

**1. In general.**

The insurance commissioner has power to cancel burial insurance licenses only in cases provided by statute. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529 (1937).

The insurance commissioner is not permitted, by the controlling statutes, to withdraw permits and licenses for any other reasons. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529 (1937).

The insurance commissioner could not cancel burial insurer's current license on ground of insurer's refusal to accept new rate and contract form adopted by insurance commissioner, and hence could not enjoin insurer's continuing in business without license. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529 (1937).

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance §§ 124, 135, 136.

## § 83-37-25. Fiscal examinations.

The insurance commissioner shall have full authority to examine the books, records, papers, and all other data belonging to or bearing on the business of any such person, firm, association, or corporation and may designate any practical accountant to make said examination at a reasonable per diem and expenses not to exceed the sum of One Hundred ($100.00) Dollars for any one (1) year, to be paid by such person, firm, association, or corporation. If upon examination the insurance commissioner be of the opinion that the capital stock of a domestic corporation has become impaired, or that any foreign company admitted to do business hereunder is insolvent, the commissioner may thereupon for said reason cancel its license to do business in this state.

Any person, firm, or corporation that may refuse to permit the insurance commissioner or any practical accountant designated by him to examine the books, records, papers, and all other data belonging to or bearing on the business of any such person, firm, or corporation shall have his, their, or its license canceled and revoked by the commissioner.

The insurance commissioner shall have full power in the regulation of any person, firm, or corporation, foreign or domestic, and anyone attempting to write burial certificate contracts without first having secured a license and having qualified under the provisions of statutes which govern, may be prosecuted under the provisions of Section 83-37-29.

**SOURCES: Codes, 1930, § 3999; 1942, § 5601; Laws, 1928, ch. 197; Laws, 1932, ch. 290.**

**Cross References** — Fees for examination of financial condition of foreign insurers, see § 83-1-27.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 67, 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance §§ 124, 135, 136.

## § 83-37-27. Licenses issued as of March 1st; term.

The annual license granted under this chapter shall be dated as of the first day of March and be good for one year from date. All such persons, firms, associations, or corporations beginning the business herein described after the first day of March in any year shall pay a proportionate part of the privilege tax herein required.

**SOURCES: Codes, 1930, § 4000; 1942, § 5602; Laws, 1928, ch. 197.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

**CJS.** 44 C.J.S., Insurance §§ 105-115, 129, 130.

## § 83-37-29. Penalties.

Any person, firm, association, or corporation engaging in the business herein described without first having complied with the provisions hereof, or any person who shall knowingly make any false statement in the reports required by this chapter as determined by the Commissioner of Insurance after written notice and hearing, shall be assessed a penalty for each violation of not less than Two Hundred Fifty Dollars ($250.00) nor more than Five Hundred Dollars ($500.00), and in addition thereto shall forfeit the license to do business in this state. Funds from such penalties shall be deposited with the State Treasurer to be placed in a fund designated as the "Insurance Department Fund."

**SOURCES: Codes, 1930, § 4001; 1942, § 5603; Laws, 1928, ch. 197; Laws, 1991, ch. 450 § 1, eff from and after passage (approved March 26, 1991).**

**Cross References —** Rules and regulations regulating sale and solicitation of burial contracts, see § 83-37-35.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 69.

**CJS.** 44 C.J.S., Insurance § 139.

## § 83-37-31. Receivership.

Should the insurance commissioner find that any person, firm, association, or corporation engaged in the business herein described has refused to pay any just claim or demand based on the contracts, or that he or they be unable to pay same after the claim or demand has been legally determined to be just and outstanding, or fail to comply with any of the licensing provisions of this chapter, the commissioner shall notify the Attorney General. The Attorney General shall apply to the chancery court for a receivership to wind up the business of such person, firm, association, or corporation, shall represent the interest of all claimants under such contracts, and shall have a right of action for the use and benefit of the claimants against the bond or security herein required for the full amount of all such claims, together with all necessary costs of such receivership.

**SOURCES: Codes, 1930, § 4002; 1942, § 5604; Laws, 1928, ch. 197; Laws, 2001, ch. 378, § 1, eff from and after July 1, 2001.**

**Cross References —** Authority of attorney general to prosecute suit on breach of contract, see § 7-5-37.

Procedure for receivership, see §§ 11-5-151 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 148 et seq.

**CJS.** 44 C.J.S., Insurance §§ 181 et seq.

## § 83-37-33. Scope of this chapter.

This chapter shall not apply to any labor union or labor union organization, whether organized in this state or not, making contracts with its members to pay money or provide funeral expenses in the event of the death of any member or any member's family. Nor shall it apply to any duly organized fraternal order making contracts with its bona fide members to pay money or provide funeral expenses in the event of the death of any such bona fide members, provided such fraternal organization do not make such contracts for profit. Nor shall it apply to any duly organized church or church associations or societies making such contracts with its bona fide members only, and not making such contracts for profit.

**SOURCES: Codes, 1930, § 4003; 1942, § 5605; Laws, 1928, ch. 197.**

**Cross References —** Maintenance of cemetery by trust fund, see § 41-43-3.

Ownership of cemetery by religious society, see § 79-11-33.

Exemption of fraternal societies from general insurance laws, see § 83-29-7.

Issuance of cease and desist orders and conduct of hearings for violation of this section, see § 83-37-35.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 63.

## § 83-37-35. Promulgation of rules and regulations regulating sale and solicitation of burial contracts; cease and desist orders.

The Commissioner of Insurance is hereby authorized to promulgate rules and regulations to the extent necessary to regulate the sale and solicitation of burial contracts and in addition may issue a cease and desist order and conduct hearings on any association or individual who is deemed to be in violation of Section 83-37-29.

**SOURCES: Laws, 1991, ch. 450 § 2, eff from and after passage (approved March 26, 1991).**

## CHAPTER 38

## Mississippi Residential Property Insurance Underwriting Association Law

Sec.
83-38-1. Purpose of chapter.
83-38-3. Definitions.
83-38-5. Mississippi Residential Property Insurance Underwriting Association.
83-38-7. Powers of association.
83-38-9. Association board of directors.
83-38-11. Benefits and obligations of association members; determination of participation.
83-38-13. Association plan of operation; approval and certification; amendment.
83-38-15. Application for coverage; forms; commission; issuance of policy; renewal.
83-38-17. Rate requirements.
83-38-19. Appeals to commissioner by persons aggrieved; related procedures; subsequent appeals to Chancery Court.
83-38-21. Availability of reports on inspections by association.
83-38-23. Nonliability of commissioner, association, or insurers for good faith statements.
83-38-25. Annual summary of association activity.
83-38-27. Examination of association affairs; public hearings; related expenses borne by association.
83-38-29. Rules and regulations.

### § 83-38-1. Purpose of chapter.

The Legislature finds that an adequate market for fire and extended coverage insurance is necessary to the economic welfare of the State of Mississippi and that without adequate and affordable insurance the orderly growth and development of the State of Mississippi is severely impeded; that insurance upon residential property in Mississippi is necessary; that while the need for such insurance is increasing, the market for such insurance is not adequate; and that the existing Mississippi Rural Risk Underwriting Association Law that provides a residual market for residential property insurance in rural areas of the state should be expanded to provide a residual market for residential property insurance in both rural areas and other areas of the state. It is the purpose of this chapter to provide a mandatory program to assure an adequate market for residential fire and extended coverage insurance in both the rural and other areas of Mississippi.

**SOURCES: Laws, 1987, ch. 422, § 35; Laws, 2003, ch. 533, § 1, eff from and after July 1, 2003.**

**Editor's Note** — Laws of 2003, ch. 533, rewrote this chapter to create the Mississippi Residential Property Insurance Underwriting Association as the replacement for the Mississippi Rural Risk Underwriting Association in order to provide a residual market for residential property insurance in both rural areas and other areas of the State.

**Cross References** — Fulfillment of purpose of chapter by plan of operation proposed by association directors, see § 83-38-13.

## § 83-38-3. Definitions.

In this chapter, unless the context otherwise requires:

(a) "Essential property insurance," in all counties of the state except the coastal area as defined in paragraph (i), means insurance against direct loss to residential property as provided by a standard fire policy and extended coverage endorsement thereon, with terms, limits, deductibles, endorsements and exclusions as approved by the Mississippi Insurance Commissioner.

"Essential property insurance" in the coastal area as defined in paragraph (i) means insurance against direct loss to residential property as provided by a standard fire policy and extended coverage endorsement thereon, with terms, limits, deductibles, endorsements and exclusions as approved by the Mississippi Insurance Commissioner, except for the risks of wind and hail storm, which shall be excepted from coverage.

The Mississippi Residential Property Underwriting Association is not required to insure the risks of wind and hail storm in the coastal area as defined in paragraph (i).

For the purposes of this chapter, essential property insurance coverage shall be limited to ninety-five percent (95%) of the market value of real and personal property that is insured by the association, excluding the value of land.

(b) "Association" means the Mississippi Residential Property Insurance Underwriting Association established pursuant to the provisions of this chapter as the successor for the Mississippi Rural Risk Underwriting Association.

(c) "Plan of operation" means the plan of operation of the association approved or promulgated by the Mississippi Insurance Commissioner pursuant to the provisions of this chapter.

(d) "Insurable interest" means any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(e) "Insurable property" means residential builder's risk and residential real property or the contents located therein, but shall not include insurance on motor vehicles, which property is determined by the association after inspection and pursuant to the criteria specified in the plan of operation, to be in an insurable condition; provided, however, any one- and two-family dwelling including, but not limited to, permanently installed manufactured housing built in substantial accordance with the local building code if applicable, which is not otherwise rendered uninsurable by reason of use, occupancy or state of repair, shall be an insurable risk within the meaning of this chapter, but neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property shall not be considered in determining insurable condition.

(f) "Commissioner" means the Mississippi Insurance Commissioner as provided in Section 83-1-3.

(g) "Net direct premiums" means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for residential fire and extended coverage insurance, including the fire and extended coverage components of comprehensive dwelling policies and homeowner policies but not including premiums on farm property, less return premiums upon cancelled contracts, dividends paid or credited to the policyholders or the unused or unabsorbed portion of premium deposits.

(h) "Rural areas" means all areas in the State of Mississippi designated as fire protection Class 9 or 10 by the Mississippi State Rating Bureau.

(i) "Coastal areas" means Hancock, Harrison and Jackson Counties.

**SOURCES: Laws, 1987, ch. 422, § 36; Laws, 2003, ch. 533, § 2, eff from and after July 1, 2003.**

**Cross References** — Issuance of property insurance by Mississippi Residential Property Insurance Underwriting Association so long as property meets definition of "insurable property," see § 83-38-15.

### RESEARCH REFERENCES

**ALR.** Condemnation proceedings as affecting insurable interest of property owner. 29 A.L.R.2d 888.

Fire insurance: insurable interest of one expecting to inherit property or take by will. 52 A.L.R.4th 1273.

What constitutes "vacant land" within meaning of liability or property insurance policy provisions. 47 A.L.R.5th 535.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 478, 479, 481, 932-977.

**CJS.** 44 C.J.S., Insurance §§ 254, 259-279.

## § 83-38-5. Mississippi Residential Property Insurance Underwriting Association.

The Mississippi Rural Risk Insurance Association is modified and expanded as provided in this chapter and shall hereafter be known as the Mississippi Residential Property Insurance Underwriting Association. The Mississippi Residential Property Insurance Underwriting Association shall consist of all insurers authorized to write and engaged in writing property insurance within this state on a direct basis. Every such insurer shall be a member of the association and shall remain a member of the association so long as the association is in existence, as a condition of its authority to continue to transact the business of insurance in this state.

**SOURCES: Laws, 1987, ch. 422, § 37; Laws, 2003, ch. 533, § 3, eff from and after July 1, 2003.**

## § 83-38-7. Powers of association.

The association, pursuant to the provisions of this chapter and the plan of operation and with respect to essential property insurance on insurable property, shall have the power on behalf of its members:

(a) To cause to be issued policies of insurance to applicants;

(b) To assume reinsurance from its members;

(c) To cede reinsurance to its members and to purchase reinsurance in behalf of its members.

**SOURCES: Laws, 1987, ch. 422, § 38, eff from and after July 1, 1987.**

## § 83-38-9. Association board of directors.

(1) The Board of Directors of the Mississippi Rural Risk Underwriting Association serving on July 1, 2003, shall serve as the Board of Directors of the Mississippi Residential Property Insurance Underwriting Association until such time as new directors are elected or appointed as provided in the plan of operation. The permanent board shall consist of five (5) representatives of members of the association and two (2) agents from the state. The agent board members shall be appointed annually by the Commissioner of Insurance.

(2) Members of the board shall serve without salary, but shall receive per diem compensation under Section 25-3-69 while attending to business of the association; members shall be reimbursed for travel expenses incurred in the discharge of their duties; all per diem compensation and travel reimbursement shall be approved by the board prior to being incurred.

**SOURCES: Laws, 1987, ch. 422, § 39; Laws, 2003, ch. 533, § 4, eff from and after July 1, 2003.**

## § 83-38-11. Benefits and obligations of association members; determination of participation.

All members of the association shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premium of such member written in this state during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association, as certified to the association by the commissioner after review of annual statements, other reports, and any other statistics the commissioner shall deem necessary to provide the information herein required and which the commissioner is hereby authorized and empowered to obtain from any member of the association.

A member shall receive credit annually for essential property insurance voluntarily written in rural and coastal areas, and its participation in the writings of the association shall be reduced in accordance with the provisions of the plan of operation.

The participation of each member in the association shall be determined annually.

**SOURCES: Laws, 1987, ch. 422, § 40; Laws, 2003, ch. 533, § 5, eff from and after July 1, 2003.**

## § 83-38-13. Association plan of operation; approval and certification; amendment.

(1) The directors of the association shall maintain a plan of operation to carry out the purposes of this chapter. Such plan shall grant proper credit annually to each member of the association for essential property insurance voluntarily written in the rural and coastal areas of the state, shall provide for a method of computing rates that is actuarially sound and shall provide for the efficient, economical, fair and nondiscriminatory administration of the association. The plan may include a method for assessment of all members for expenses necessary to operate the association, selection of directors from the members of the association, assessment of members to defray losses and expenses, underwriting standards, procedures for the acceptance and cession of reinsurance, procedures for determining the amount of insurance to be provided to specific risks, time limits and procedures for processing applications for insurance, and other provisions as may be deemed necessary by the commissioner to carry out the purposes of this chapter.

(2) The plan of operation and any proposed amendments thereto are subject to review and approval by the commissioner to fulfill the purposes provided by Section 83-38-1. In the review of the plan, the commissioner may consult with the directors of the association and may seek any further information which is necessary for a decision. If the commissioner approves the plan, the commissioner shall certify such approval to the directors, and the plan shall become effective after such certification. If the commissioner disapproves all or any part of the plan of operation, the commissioner shall return the same to the directors with a written statement of the reasons for disapproval and any recommendations. The directors may alter the plan in accordance with the commissioner's recommendation or, within thirty (30) days from the date of disapproval, may return a new plan to the commissioner. Should the directors fail to submit a proposed plan of operation which is acceptable to the commissioner, or accept the recommendation of the commissioner within thirty (30) days after disapproval of the plan, the commissioner shall promulgate and place into effect a plan of operation certifying the same to the directors of the association. A plan promulgated by the commissioner shall take effect thirty (30) days after certification to the directors.

(3) The directors of the association, subject to the approval of the commissioner, may amend the plan of operation at any time. The commissioner may review the plan of operation at any time deemed expedient or prudent, but not less than once in each calendar year.

**SOURCES: Laws, 1987, ch. 422, § 41; Laws, 2003, ch. 533, § 6, eff from and after July 1, 2003.**

**Cross References —** Creation and functions of board of directors, see § 83-38-9.

## § 83-38-15. Application for coverage; forms; commission; issuance of policy; renewal.

(1) Any person having an insurable interest in insurable property is entitled to apply to the association for such coverage and for an inspection of the property. Such application may be made on behalf of the applicant by a broker or agent licensed in Mississippi authorized by him. Every such application shall be submitted on forms prescribed by the association after consultation with the commissioner. The application shall contain an inquiry as to whether there are unpaid premiums due from the applicant for fire insurance on the property.

The commission paid to the submitting broker or agent shall be equal to ten percent (10%) of the premium collected.

(2) If the association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance for a term of one (1) year. Any policy issued pursuant to the provisions of this section shall be renewed annually so long as:

(a) The property continues to meet the definition of "insurable property" set forth in Section 83-38-3(e);

(b) A properly completed application for renewal shall have been received by the association on or before the date of renewal; and

(c) Property premiums have been received by the association on or before the date of renewal.

(3) If the association for any reason denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant, or takes no action on an application within the time prescribed in the plan of operation, the applicant may appeal to the commissioner. The commissioner or a member of the staff of the Insurance Department designated by the commissioner, after reviewing the facts, may determine if the association acted in accordance with the law and the plan of operation. In carrying out the duties pursuant to this section, the commissioner may request, and the association shall provide, any information deemed necessary to a determination concerning the reasons for the denial or delay of the application.

**SOURCES: Laws, 1987, ch. 422, § 42; Laws, 2003, ch. 533, § 7, eff from and after July 1, 2003.**

## § 83-38-17. Rate requirements.

The forms, rates, rating plans, and rating rules applicable to the insurance written by the association shall be those approved for use of the association by the commissioner. Surcharges may be used as approved by the commissioner. Rates shall be actuarially sound and nondiscretionary as to the same class of risk.

**SOURCES: Laws, 1987, ch. 422, § 43; Laws, 2003, ch. 533, § 8, eff from and after July 1, 2003.**

## § 83-38-19. Appeals to commissioner by persons aggrieved; related procedures; subsequent appeals to Chancery Court.

Any person insured pursuant to this chapter, or his representative, or any affected insurer who may be aggrieved by an act, ruling, or decision of the association, within thirty (30) days after such ruling, is entitled to appeal to the commissioner. A hearing before the commissioner upon such appeal shall be in accordance with the procedures promulgated by the commissioner. The commissioner is authorized to appoint a member of the Insurance Department staff for the purpose of hearing such appeals, and a ruling based upon such hearing shall have the same effect as if heard by the commissioner. All persons or insureds aggrieved by any order or decision of the commissioner may appeal, within thirty (30) days of such order or decision to the Chancery Court of the First Judicial District of Hinds County.

**SOURCES: Laws, 1987, ch. 422, § 44, eff from and after July 1, 1987.**

## § 83-38-21. Availability of reports on inspections by association.

All reports of inspection performed by or on behalf of the association are available to the members of the association, applicants, agents, brokers and the commissioner.

**SOURCES: Laws, 1987, ch. 422, § 45; Laws, 2003, ch. 533, § 9, eff from and after July 1, 2003.**

## § 83-38-23. Nonliability of commissioner, association, or insurers for good faith statements.

There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the association or its directors, agents or employers, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearings conducted in connection therewith under the provisions of this chapter.

**SOURCES: Laws, 1987, ch. 422, § 46, eff from and after July 1, 1987.**

## § 83-38-25. Annual summary of association activity.

The association shall file in the office of the commissioner on or before March 1 of each year a statement which summarizes the transactions, conditions, operations and affairs of the association during the preceding fiscal year ending December 31. The statement shall contain such matters and information and be in a form prescribed by the commissioner. At any time the commissioner may require the association to furnish any additional information with respect to its transactions or any other matter which the commissioner deems to be material in evaluating the operation and experience of the association.

**SOURCES: Laws, 1987, ch. 422, § 47, eff from and after July 1, 1987.**

## § 83-38-27. Examination of association affairs; public hearings; related expenses borne by association.

The commissioner may make an examination into the affairs of the association at any time. In undertaking such examination, the commissioner is empowered to hold a public hearing. The expenses of such examination shall be borne and paid by the association.

**SOURCES: Laws, 1987, ch. 422, § 48, eff from and after July 1, 1987.**

## § 83-38-29. Rules and regulations.

The commissioner is empowered to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out, and make effective the provisions of this chapter.

**SOURCES: Laws, 1987, ch. 422, § 49, eff from and after July 1, 1987.**

# CHAPTER 39

## Bail Bonds and Bondsmen

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### § 83-39-1. Definitions.

The following terms when used in this chapter shall have the following meanings:

(a) "Department" means the Department of Insurance.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Insurer" means any domestic or foreign insurance corporation or association engaged in the business of insurance or suretyship which has qualified to transact surety or casualty business in this state.

(d) "Professional bail agent" means any individual who shall furnish bail, acting as a licensed personal surety agent or as a licensed limited surety agent representing an insurer as defined by this chapter. The above definition shall not include, and this chapter does not apply to, any individual who is not licensed under this chapter who acts as personal surety in instances where there is no compensation charged or received for such service.

(e) "Soliciting bail agent" means any person who, as an agent or employee of a professional bail agent, or as an independent contractor, for compensation or otherwise, shall solicit, advertise or actively seek bail bond business for or on behalf of a professional bail agent and who assists the professional bail agent in presenting the defendant in court when required or assists in the apprehension and surrender of the defendant to the court or keeps the defendant under necessary surveillance.

(f) "Bail enforcement agent" means a person who assists the professional bail agent in presenting the defendant in court when required, or who assists in the apprehension and surrender of the defendant to the court or who keeps the defendant under necessary surveillance. Nothing herein shall affect the right of professional bail agents to have counsel or to ask assistance of law enforcement officers.

(g) "Limited surety agent" means any individual who is appointed by an insurer by power of attorney to execute or countersign bail bonds in connection with judicial proceedings, and who is duly licensed by the commissioner to represent such insurer for the restricted lines of bail, fidelity and surety, after successfully completing a limited examination by the department for the restricted lines of business.

(h) "Personal surety agent" means any individual who, having posted the necessary qualification bond with the commissioner as required by Section 83-39-7, and duly licensed by the commissioner, may execute and sign bail bonds in connection with judicial proceedings. All new personal surety agents licensed after July 1, 1994, shall complete successfully a limited examination by the department for the restricted lines of business.

(i) "Surety" means the insurer or the personal surety agent guaranteeing the bail bond and for the purpose of process does not mean the agent of such insurer or personal surety agent.

(j) "Bail" means the use of money, property or other security to cause the release of a defendant from custody and secure the appearance of a defendant in criminal court proceedings, or the monitoring or supervision of defendants who are released from custody on recognizance, parole or probation, except when such monitoring or supervision is conducted after conviction, sentencing or other adjudication and solely by public employees.

**SOURCES: Codes, 1942, § 8745-01; Laws, 1968, ch. 341, § 1; Laws, 1994, ch. 495, § 1; Laws, 2000, ch. 384, § 1; Laws, 2003, ch. 452, § 1; Laws, 2010, ch. 466, § 1, eff from and after July 1, 2010.**

**Amendment Notes** — The 2010 amendment inserted "who is not licensed under this chapter" in (d); and added (j).

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

## JUDICIAL DECISIONS

**3. State regulation.**

While bail bondsmen licenses were governed by state law and county sheriffs could not revoke a license issued by the state under the scheme of Miss. Code Ann. §§ 83-39-1 et seq., where a state judge had held that county sheriffs had no discretion to suspend bond-writing rights, the district court's summary judgment to defendant county on a due process claim was reversed; defendant sheriff's decision to remove plaintiff bonding agents from the approved list could be the basis of the county's due process liability based on policy and custom. Hampton Co. Nat'l Sur. LLC v. Tunica County Miss., 543 F.3d 221 (5th Cir. 2008).

## ATTORNEY GENERAL OPINIONS

A scire facias may be personally served on a limited surety agent, and that process will be binding on the insurer represented by that agent. Johnson, November 6, 1998, A.G. Op. #98-0672.

A bail enforcement agent may be employed by more than one professional bail agent, however, the agent's license should indicate each professional bail agent by whom they are employed. Beshears, May 28, 2004, A.G. Op. 04-0219.

## RESEARCH REFERENCES

**Am Jur.** 74 Am. Jur. 2d, Suretyship § 202.

3A Am. Jur. Legal Forms 2d, Bail and Recognizance §§ 35:2 et seq. (sureties).

**CJS.** 44 C.J.S., Insurance § 19.

## § 83-39-3. Individual license required.

(1) No person shall act in the capacity of professional bail agent, soliciting bail agent or bail enforcement agent, as defined in Section 83-39-1, or perform any of the functions, duties or powers of the same unless that person shall be qualified and licensed as provided in this chapter. The terms of this chapter shall not apply to any automobile club or association, financial institution, insurance company or other organization or association or their employees who execute bail bonds on violations arising out of the use of a motor vehicle by their members, policyholders or borrowers when bail bond is not the principal benefit of membership, the policy of insurance or of a loan to such member, policyholder or borrower.

(2)(a) No license shall be issued or renewed except in compliance with this chapter, and none shall be issued except to an individual. No firm, partnership, association or corporation, as such, shall be so licensed. No professional bail agent shall operate under more than one (1) trade name. A soliciting bail agent and bail enforcement agent shall operate only under the professional bail agent's name. No license shall be issued to or renewed for any person who has ever been convicted of a felony or any crime involving moral turpitude or who is under twenty-one (21) years of age. No person engaged as a law enforcement or judicial official or attorney shall be licensed hereunder. A person who is employed in any capacity at any jail or corrections facility that houses state, county or municipal inmates who are bailable, whether the person is a public employee, independent contractor, or the employee of an independent contractor, may not be licensed under this section.

(b)(i) No person who is a relative of either a sworn state, county or municipal law enforcement official or judicial official, or an employee, independent contractor or the contractor's employee of any police department, sheriff's department, jail or corrections facility that houses or holds federal, state, county or municipal inmates who are bailable, shall write a bond in the county where the law enforcement entity or court in which the person's relative serves is located. "Relative" means a spouse, parent, grandparent, child, sister, brother, or a consanguineous aunt, uncle, niece or nephew. Violation of this prohibition shall result in license revocation.

(ii) No person licensed under this chapter shall act as a personal surety agent in the writing of bail during a period he or she is licensed as a limited surety agent, as defined herein.

(iii) No person licensed under this chapter shall give legal advice or a legal opinion in any form.

(3) The department is vested with the authority to enforce this chapter. The department may conduct investigations or request other state, county or local officials to conduct investigations and promulgate such rules and regulations as may be necessary for the enforcement of this chapter. The department may establish monetary fines and collect such fines as necessary for the enforcement of such rules and regulations. All fines collected shall be deposited in the Special Insurance Department Fund for the operation of that agency.

(4) Each license issued hereunder shall expire biennially on the last day of September, unless revoked or suspended prior thereto by the department, or upon notice served upon the commissioner by the insurer that the authority of a limited surety agent to act for or in behalf of such insurer had been terminated, or upon notice served upon the commissioner by a professional bail agent that the employment of a soliciting bail agent or bail enforcement agent had been terminated by such professional bail agent. Licenses shall expire on the last day of September of each odd-numbered year.

(5) The department shall prepare and deliver to each licensee a license showing the name, address and classification of such licensee, and shall certify that the person is a licensed professional bail agent, being designated as a personal surety agent or a limited surety agent, a soliciting bail agent or a bail enforcement agent. In addition, the license, if for a soliciting bail agent or bail enforcement agent, shall show the name of the professional bail agent and any other information as the commissioner deems proper.

(6) The commissioner, after a hearing under Section 83-39-17, may refuse to issue a privilege license for a soliciting bail agent to change from one (1) professional bail agent to another if he owes any premium or debt to the professional bail agent with whom he is currently licensed. The commissioner, after a hearing under Section 83-39-17, shall refuse to issue a license for a limited surety agent if he owes any premium or debt to an insurer to which he has been appointed. If a license has been granted to a limited surety agent or a soliciting bail agent who owed any premium or debt to an insurer or professional bail agent, the commissioner, after a hearing under Section 83-39-17, shall revoke the license.

(7)(a) Before the issuance of any professional bail agent, soliciting bail agent or bail enforcement agent license, the applicant shall submit proof of successful completion of forty (40) classroom hours of prelicensing education approved by the Professional Bail Agents Association of Mississippi, Inc., and conducted by persons or entities approved by the Professional Bail Agents Association of Mississippi, Inc. The hours required by this subsection shall be classroom hours and may not be acquired through correspondence or over the Internet. Prelicensing education is not required for a professional bail agent, bail soliciting agent or bail enforcement agent licensee who applies for a different category of license if the prior license has remained in effect without any action taken against it and the applicant has successfully completed the continuing education requirements under this section for all periods between the completion of the prelicensing education and the submission of the application for a license in a different category.

(b) Beginning on July 1, 2011, in order to assist the department in determining an applicant's suitability for a license under this chapter, the applicant shall submit a set of fingerprints with the submission of an application for license. The department shall forward the fingerprints to the Department of Public Safety for the purpose of conducting a criminal history record check. If no disqualifying record is identified at the state level, the fingerprints shall be forwarded by the Department of Public Safety to the Federal Bureau of Investigation for a national criminal history record check. Fees related to the criminal history record check shall be paid by the applicant to the commissioner and the monies from such fees shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

(8)(a) Before the renewal of the license of any professional bail agent, soliciting bail agent or bail enforcement agent, the applicant shall submit proof of successful completion of continuing education hours as follows:

(i) There shall be no continuing education required for the first year of an original license;

(ii) Except as provided in subparagraph (i), eight (8) classroom hours of continuing education for each year or part of a year of the two-year license period, for a total of sixteen (16) hours per license period.

(b) If an applicant for renewal failed to obtain the required eight (8) hours for each year of the license period during the actual license year in which the education was required to be obtained, the applicant shall not be eligible for a renewal license but shall be required to obtain an original license and be subject to the education requirements set forth in subsection (7). The commissioner shall not be required to comply with Section 83-39-17 in denying an application for a renewal license under this paragraph (b).

(c) The education hours required under this subsection (8) shall consist of classroom hours approved by the Professional Bail Agents Association of Mississippi, Inc., and provided by persons or entities approved by the Professional Bail Agents Association of Mississippi, Inc. The hours required by this subsection shall be classroom hours and may not be acquired through correspondence or over the Internet.

(d) The continuing education requirements under this subsection (8) shall not be required for renewal of a professional bail agent license for any applicant who is sixty-five (65) years of age and who has been licensed as a professional bail agent for a continuous period of twenty (20) years immediately preceding the submission of the application as evidenced by submission of an affidavit, under oath, on a form prescribed by the department, signed by the licensee attesting to satisfaction of the age, licensing, and experience requirements of this paragraph (d).

(9) No license as a professional bail agent shall be issued unless the applicant has been duly licensed by the department as a soliciting bail agent for a period of three (3) consecutive years immediately preceding the submission of the application. However, this subsection (9) shall not apply to any person who was licensed as a professional bail agent before July 1, 2011.

(10) A nonresident person may be licensed as a professional bail agent, bail soliciting agent or bail enforcement agent if:

(a) The person's home state awards licenses to residents of this state on the same basis; and

(b) The person has satisfied all requirements set forth in this chapter.

**SOURCES: Codes, 1942, § 8745-02; Laws, 1968, ch. 341, § 2; Laws, 1994, ch. 495, § 2; Laws, 1997, ch. 410, § 19; Laws, 1999, ch. 497, § 1; Laws, 2001, ch. 353, § 1; Laws, 2001, ch. 563, § 1; Laws, 2006, ch. 586, § 1; Laws, 2007, ch. 501, § 3; Laws, 2008, ch. 467, § 1; Laws, 2010, ch. 466, § 2; Laws, 2011, ch. 463, § 4, eff from and after July 1, 2011.**

**Joint Legislative Committee Note** — Section 1 of ch. 353, Laws of 2001, effective from and after July 1, 2001 (approved March 11, 2001), amended this section. Section 1 of ch. 563, Laws of 2001, effective from and after July 1, 2001 (approved April 7, 2001), also amended this section. As set out above, this section reflects the language of Section 1 of ch. 563, Laws of 2001, pursuant to Section 1-3-79, which provides that whenever the same section of law is amended by different bills during the same legislative session, and the effective dates of the sections are the same, the amendment with the latest approval date shall supersede all other amendments to the same section approved on an earlier date.

Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in (8)(a) by inserting "the" preceding "license of any professional bail agent," so that "Before the renewal of license" now reads "Before the renewal of the license." The Joint Committee ratified the correction at its August 5, 2008, meeting.

**Amendment Notes** — The 2010 amendment made minor stylistic changes in (2)(b)(i) and (8)(a)(ii); added (2)(b)(ii) and redesignated former (2)(b)(ii) and (2)(b)(iii) as (2)(b)(iii) and (2)(b)(iv), respectively; and added the (7)(a) designation and (7)(b).

The 2011 amendment rewrote the section.

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

## ATTORNEY GENERAL OPINIONS

The term law enforcement official as used in the context of this section would include any employee of a sheriff's office, including dispatchers and jailers. The term judicial official would include all employees of any court that enforces criminal laws. Dale, April 27, 1995, A.G. Op. #95-0243.

A professional bail agent is required to obtain a license under Section 83-39-3. Any professional bondsman with a valid license may serve as a surety for an appearance bond in municipal court. Cadle, November 15, 1996, A.G. Op. #96-0791.

A professional bondsman's, with a valid license under Section 83-39-3, may be revoked or suspended for the conviction of a felony or a crime involving moral turpitude, however we are not aware of any provision that restricts a bondsman with a valid license from serving as a surety simply because he was charged with an offense and was subsequently released on bond. Cadle, November 15, 1996, A.G. Op. #96-0791.

A convicted felon cannot be issued a professional bail agent's license, although the Department of Insurance has discretion to take action against an individual who has already been licensed and then is convicted of a felony. Dale, Nov. 5, 1999, A.G. Op. #1999-0579.

For the purposes of the statute, a correctional officer is a law enforcement official and, therefore, is prohibited from obtaining a bail bondsman license. Walker, Mar. 30, 2001, A.G. Op. #01-0183.

A sheriff or court may require a bondsman to prove he has enough assets to cover all outstanding bonds written by him or his soliciting agents prior to accepting a bond from him or his soliciting agents; however, a court does not have the authority to require a licensed professional bondsman to post collateral to ensure payment on outstanding bonds. Payne, Sept. 13, 2002, A.G. Op. #02-0513.

A court does not have authority to require a bondsman to maintain an office within the city limits or to require the bondsman to maintain set business hours; however, a court may require a bondsman to provide an address and be reasonably available for service of process. Payne, Sept. 13, 2002, A.G. Op. #02-0513.

A bail enforcement agent may be employed by more than one professional bail agent, however, the agent's license should indicate each professional bail agent by whom they are employed. Beshears, May 28, 2004, A.G. Op. 04-0219.

Where the Department of Insurance has received an application for licensing as a bail agent from a person who pled guilty to a felony, but pursuant to Section 99-15-26, the court did not accept the guilty plea, there has been no conviction of a felony for purposes of Section 83-39-3(2)(a); however, Section 83-39-9 requires an applicant to submit proof of good moral character, thus, the Department may examine the behavior and conduct leading to the guilty plea and make a determination as to whether the applicant has good moral character. Dale, May 20, 2005, A.G. Op. 05-0213.

### RESEARCH REFERENCES

**Am Jur.** 74 Am. Jur. 2d, Suretyship § 203.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-5. License requirements.

Any person desiring to engage in the business of professional bail agent, soliciting bail agent, or bail enforcement agent in this state shall apply to the department for a license on forms prepared and furnished by the department. The application for a license, or renewal thereof, shall set forth, under oath, the following information:

(a) Full name, age, date of birth, social security number, residence during the previous five (5) years, occupation and business address of the applicant.

(b) Spouse's full name, occupation and business address.

(c) A photograph of the applicant and a full set of fingerprints for the initial application and, thereafter, as requested by the department.

(d) A statement that he is not licensed to practice law in the State of Mississippi or any other state and that no attorney or any convicted felon has any interest in his application, either directly or indirectly.

(e) Any other information as may be required by this chapter or by the department.

(f) In the case of a professional bail agent, a statement that he will actively engage in the bail bond business.

(g) In the case of a soliciting bail agent, a statement that he will be employed or used by only one (1) professional bail agent and that the professional bail agent will supervise his work and be responsible for his conduct in his work. A professional bail agent shall sign the application of each soliciting bail agent employed or used by him.

Each application or filing made under this section shall include the social security number(s) of the applicant in accordance with Section 93-11-64, Mississippi Code of 1972.

**SOURCES: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 3; Laws, 1997, ch. 410, § 20; Laws, 1997, ch. 588, § 71; Laws, 2007, ch. 501, § 4, eff from and after June 1, 2007.**

**Joint Legislative Committee Note —** Section 20 of ch. 410, Laws of 1997, amended this section, effective July 1, 1997 (approved March 24, 1997). Section 71 of ch. 588, Laws of 1997, effective July 1, 1997 (approved April 24, 1997), also amended this section. As set out above, this section reflects the language of Section 71 of ch. 588, Laws of 1997, pursuant to Section 1-3-79 which provides that whenever the same section of law is amended by different bills during the same legislative session, and the effective dates of the amendments are the same, the amendment with the latest approval date shall supersede all other amendments to the same section approved on an earlier date.

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-7. Qualification bond; return of defendant out on bond.

(1) Each applicant for a professional bail agent license who acts as personal surety shall be required to post a qualification bond in the amount of Thirty Thousand Dollars ($30,000.00). The qualification bond shall be made by depositing with the commissioner the aforesaid amount of bonds of the United States, the State of Mississippi or any agency or subdivision thereof, or a certificate of deposit issued by an institution whose deposits are insured by the Federal Deposit Insurance Corporation and made payable jointly to the owner and the Department of Insurance, or shall be written by an insurer as defined in this chapter, shall meet the specifications as may be required and defined in this chapter, and shall meet such specifications as may be required and approved by the department. The bond shall be conditioned upon the full and prompt payment of any bail bond issued by such professional bail agent into the court ordering the bond forfeited. The bond shall be to the people of the

State of Mississippi in favor of any court of this state, whether municipal, justice, county, circuit, Supreme or other court. If any bond issued by a professional bail agent is declared forfeited and judgment entered thereon by a court of proper jurisdiction as authorized in Section 99-5-25, and the amount of the bond is not paid within ninety (90) days, that court shall order the department to declare the qualification bond of the professional bail agent to be forfeited and the license revoked. If the bond was not forfeited correctly under Section 99-5-25, it shall be returned to the court as uncollectible. The department shall then order the surety on the qualification bond to deposit with the court an amount equal to the amount of the bond issued by the professional bail agent and declared forfeited by the court, or the amount of the qualification bond, whichever is the smaller amount. The department shall, after hearing held upon not less than ten (10) days' written notice, suspend the license of the professional bail agent until such time as another qualification bond in the required amount is posted with the department. The revocation of the license of the professional bail agent shall also serve to revoke the license of each soliciting bail agent and bail enforcement agent employed or used by such professional bail agent. In the event of a final judgment of forfeiture of any bail bond written under the provisions of this chapter, the amount of money so forfeited by the final judgment of the proper court, less all accrued court costs and excluding any interest charges or attorney's fees, shall be refunded to the bail agent or his insurance company upon proper showing to the court as to which is entitled to same, provided the defendant in such cases is returned to the sheriff of the county to which the original bail bond was returnable within twelve (12) months of the date of such final judgment, or proof made of incarceration of the defendant in another jurisdiction, and that a "Hold Order" has been placed upon the defendant for return of the defendant to the sheriff upon release from the other jurisdiction, the return to the sheriff to be the responsibility of the professional bail agent as provided in subsection (2) of this section, then the bond forfeiture shall be stayed and remission made upon petition to the court, in the amount found in the court's discretion to be just and proper. A bail agent licensed under this chapter shall have a right to apply for and obtain from the proper court an extension of time delaying a final judgment of forfeiture if such bail agent can satisfactorily establish to the court wherein such forfeiture is pending that the defendant named in the bail bond is lawfully in custody outside of the State of Mississippi.

(2) The professional bail agent shall satisfy the responsibility to return the defendant who has been held by a "Hold Order" in another jurisdiction upon release from the other jurisdiction:

(a) By personally returning the defendant to the sheriff at no cost to the county; or

(b) Where the other jurisdiction will not release the defendant to any person other than a law enforcement officer, by reimbursing to the county the reasonable cost of the return of the defendant, not to exceed the cost that would be entailed if the option in paragraph (a) of this subsection were available.

**SOURCES: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 4; Laws, 1997, ch. 410, § 21; Laws, 1998, ch. 323, § 6; Laws, 1999, ch. 399, § 1; Laws, 2000, ch. 456, § 1; Laws, 2003, ch. 351, § 1; Laws, 2004, ch. 363, § 1; Laws, 2005, ch. 479, § 1; Laws, 2007, ch. 501, § 5, eff from and after June 1, 2007.**

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

Transfer of qualification bond, see, § 83-39-8.

## JUDICIAL DECISIONS

**1. In general.**

Where a bail bondsman failed to take any action either prior to, on the day of, or within the 12-month period after the entry of final judgment to obtain relief and have a bond remitted to him, an application which was filed approximately 17 months after entry of final judgment was barred. State v. Ellis, 770 So. 2d 1041 (Miss. Ct. App. 2000).

Section 83-39-7, which provides that a bondsman may petition a court either for a refund of the money forfeited on final judgment or for a stay and remission of forfeiture, does not contemplate a stay and remission of forfeiture where the defendant is returned within 12 months but the judgment remains unpaid. Sides v. State, 519 So. 2d 1222 (Miss. 1988).

In an action by a bail bond corporation to set aside a final judgment of forfeiture of bail bonds written by the corporation, the trial court properly denied a refund where the final judgment of forfeiture had been entered before the corporation applied for and received several extensions of time to produce the defendant; such extensions of time were invalid since they may be obtained under this section only for the purpose of "delaying a final judgment of forfeiture." Allied Fid. Ins. Co. v. State, 384 So. 2d 860 (Miss. 1980).

Pursuant to § 83-39-7, a bail bondsman who can establish that a defendant is in lawful custody in another jurisdiction is entitled to an extension of time delaying final judgment on an appearance bond. Wood v. State, 345 So. 2d 616 (Miss. 1977).

## ATTORNEY GENERAL OPINIONS

Remission of bail bond should go to the licensed professional bondsmen, not to a third party who paid the judgment on his behalf; however, in the event of a known dispute, the court can order the remission interpled into chancery court with claimants as defendants for a determination of rights. Boothe, May 13, 1992, A.G. Op. #92-0330.

Where bond issued by professional bondsman has been forfeited, form which simply states supporting facts and orders Insurance Commissioner to revoke license of offending bondsman is sufficient to satisfy requirements of section. McCarty, July 15, 1992, A.G. Op. #92-0510.

Plain language of statute requires new total bond of $10,000.00 where bondsman making application for renewal has furnished bail in fifty or more cases. Weeks, March 2, 1994, A.G. Op. #94-0065.

If a defendant fails to appear for court as scheduled, the court should order the bond forfeited, issue a judgment nisi against the bondsman returnable for ninety days, and then the bonding company has ninety days to bring the defendant before the court; if the defendant is not produced within that period, then the judgment becomes final, the court may take actions to collect on the bond, and if the bondsman has not paid the bond within ninety days after the final judgment, then the court must order the Department of Insurance to revoke the license of the bondsman. Edwards, Aug. 19, 1997, A.G. Op. #97-0495.

### RESEARCH REFERENCES

**ALR.** State statutes making default on bail a separate criminal offense. 63 A.L.R.4th 1064.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

3A Am. Jur. Legal Forms 2d, Bail and Recognizance §§ 35:2 et seq. (sureties).

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-8. Transfer of qualification bond.

A personal surety agent licensed under this chapter or the executor, trustee or guardian of his estate shall be allowed to transfer the qualification bond required under Section 83-39-7 to another person, provided that person meets all requirements for a license under this chapter and assumes all outstanding liabilities of the personal surety agent. The transferee shall be authorized to conduct the business of the personal surety agent existing and pending at the time of the transferee. The transferee shall submit an application with the fee and proof of education required by Section 83-39-5, which application shall be processed expeditiously and with priority by the department.

**SOURCES: Laws, 2007, ch. 501, § 1, eff from and after June 1, 2007.**

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

## § 83-39-9. Issuance of license.

The department upon receipt of the license application, the required fee, and proof of good moral character and, in the case of a professional bail agent, an approved qualification bond in the required amount, shall issue to the applicant a license to do business as a professional bail agent, soliciting bail agent or bail enforcement agent as the case may be.

No licensed professional bail agent shall have in his employ in the bail bond business any person who could not qualify for a license under this chapter, nor shall any licensed professional bail agent have as a partner or associate in such business any person who could not so qualify.

**SOURCES: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 5, eff from and after July 1, 1994.**

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

### JUDICIAL DECISIONS

**1. Suspension of license.**

Appellate court affirmed a trial court judgment that affirmed the suspension of bail bond agent for six months from the bail bonding business pursuant to Miss. Code Ann. § 83-39-15 because the agent employed her husband, a convicted felon, in her business in violation of Miss. Code Ann. § 83-39-9. Davis-Everett v. Dale, 926 So. 2d 279 (Miss. Ct. App. 2006).

### ATTORNEY GENERAL OPINIONS

Any person, regardless of the position to be held, that could not qualify for a license may not be employed by a licensed professional bail agent. Harrell, May 27, 2005, A.G. Op. 05-0196.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-11. License fees.

Each license application and application for license renewal to engage in the business of professional bail agent shall be accompanied by a fee of One Hundred Dollars ($100.00). Each license application and application for license renewal to engage in the business of soliciting bail agent or bail enforcement agent shall be accompanied by a fee of Forty Dollars ($40.00).

**SOURCES: Codes, 1942, § 8745-04; Laws, 1968, ch. 341, § 4; Laws, 1994, ch. 495, § 6; Laws, 2007, ch. 501, § 6, eff from and after June 1, 2007.**

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-13. Annual reports required; maintenance and registration of office physically located in Mississippi municipality or county required.

(1) Each professional bail agent licensed under this chapter, under oath, shall report annually to the department on forms prescribed by the department. This report shall be made on a calendar basis before June 1 of each year.

(2)(a) For purposes of applicable examinations, a professional bail agent licensed in this state shall maintain at least one (1) office physically located in any municipality or county in this state, to serve as his principal place of business operations where records pertaining to his bail agent business conducted in Mississippi are maintained and this office location shall be registered with the Department of Insurance.

(b) When applying for an original or renewal license as a professional bail agent, the applicant shall indicate the address of the office location to serve as his principal place of business operations, and this address shall be evidenced on the face of the license issued to the licensee.

(c) If for any reason the professional bail agent changes the location of his principal place of business operations, removes to another state, or no longer continues in the profession as a bail agent, the bail agent shall register the new location with the department, or notify the department of his removal from the state or his cessation of business as a professional bail agent as appropriate.

**SOURCES: Codes, 1942, § 8745-05; Laws, 1968, ch. 341, § 5; Laws, 1984, ch. 436; Laws, 1994, ch. 495, § 7; Laws, 1998, ch. 323, § 7; Laws, 2011, ch. 463, § 5, eff from and after July 1, 2011.**

**Amendment Notes** — The 2011 amendment added (2)(a) through (c).

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

### ATTORNEY GENERAL OPINIONS

Sheriff can approve bond for prisoner in his custody in each individual case, but sheriff has no authority to "approve" bondsman for city for all purposes. Dean Oct. 6, 1993, A.G. Op. #93-0656.

Any party approving bond could require financial information of person seeking to post bond. Dean Oct. 6, 1993, A.G. Op. #93-0656.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 70.

**CJS.** 44 C.J.S., Insurance § 96.

## § 83-39-15. Grounds for denial, suspension, revocation, and refusal to renew license.

(1) The department may deny, suspend, revoke or refuse to renew, as may be appropriate, a license to engage in the business of professional bail agent, soliciting bail agent, or bail enforcement agent for any of the following reasons:

(a) Any cause for which the issuance of the license would have been refused had it then existed and been known to the department.

(b) Failure to post a qualification bond in the required amount with the department during the period the person is engaged in the business within this state or, if the bond has been posted, the forfeiture or cancellation of the bond.

(c) Material misstatement, misrepresentation or fraud in obtaining the license.

(d) Willful failure to comply with, or willful violation of, any provision of this chapter or of any proper order, rule or regulation of the department or any court of this state.

(e) Conviction of felony or crime involving moral turpitude.

(f) Default in payment to the court should any bond issued by such bail agent be forfeited by order of the court.

(g) Being elected or employed as a law enforcement or judicial official.

(h) Engaging in the practice of law.

(i) Writing a bond in violation of Section 83-39-3(2)(b)(i) and (ii).

(j) Giving legal advice or a legal opinion in any form.

(k) Acting as or impersonating a bail agent without a license.

(2) In addition to the grounds specified in subsection (1) of this section, the department shall be authorized to suspend the license, registration or permit of any person for being out of compliance with an order for support, as defined in Section 93-11-153. The procedure for suspension of a license, registration or permit for being out of compliance with an order for support, and the procedure for the reissuance or reinstatement of a license, registration or permit suspended for that purpose, and the payment of any fees for the reissuance or reinstatement of a license, registration or permit suspended for that purpose, shall be governed by Section 93-11-157 or 93-11-163, as the case may be. If there is any conflict between any provision of Section 93-11-157 or 93-11-163 and any provision of this chapter, the provisions of Section 93-11-157 or 93-11-163, as the case may be, shall control.

**SOURCES: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 8; Laws, 1996, ch. 507, § 89; Laws, 2001, ch. 563, § 2; Laws, 2010, ch. 466, § 3, eff from and after July 1, 2010.**

**Amendment Notes —** The 2010 amendment substituted "a license to engage in the business" for "the license of any person engaged in the business" in the introductory paragraph in (1); rewrote (1)(i), which formerly read: "Writing a bond for a person arrested by a spouse or the law enforcement entity which a spouse serves as a law enforcement official or employee"; and added (1)(k).

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

## ATTORNEY GENERAL OPINIONS

A convicted felon cannot be issued a professional bail agent's license, although the Department of Insurance has discretion to take action against an individual who has already been licensed and then is convicted of a felony. Dale, Nov. 5, 1999, A.G. Op. #99-0579.

## JUDICIAL DECISIONS

1. Suspension of license.
2. State/local regulation.

**1. Suspension of license.**

Appellate court affirmed a trial court judgment that affirmed the suspension of bail bond agent for six months from the bail bonding business pursuant to Miss. Code Ann. § 83-39-15 because the agent employed her husband, a convicted felon, in her business in violation of Miss. Code Ann. § 83-39-9. Davis-Everett v. Dale, 926 So. 2d 279 (Miss. Ct. App. 2006).

**2. State/local regulation.**

Where a state judge had held that county sheriffs had no discretion under Miss. Code Ann. § 89-39-15 to suspend bond-writing rights, the district court's summary judgment to defendant county on a due process claim was reversed; defendant sheriff's decision to remove plaintiff bonding agents from the approved list could be the basis of the county's due process liability based on policy and custom. Hampton Co. Nat'l Sur. LLC v. Tunica County Miss., 543 F.3d 221 (5th Cir. 2008).

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 77.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-17. Hearing.

Before any license shall be refused or suspended or revoked, or the renewal thereof refused hereunder, the commissioner shall give notice of his intention to do so, by registered mail, to the applicant or licensee and to the insurer or professional bail agent appointing or employing the applicant or licensee, as the case may be, and shall set a date, not less than twenty (20) days from the date of mailing the notice, when the applicant or licensee and a duly authorized representative of the insurer or professional bail agent may appear to be heard and produce evidence. In the conduct of the hearing, the commissioner or any regular salaried employee specially designated by him for this purpose shall have power to administer oaths, to require the appearance of and examine any person under oath, and to require the production of books, records, or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of the hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office and notice of the findings sent by registered mail to the applicant or licensee and the insurer or professional bail agent concerned.

**SOURCES: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 9; Laws, 2001, ch. 461, § 2, eff from and after July 1, 2001.**

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Exemption from requirements of this section for denial of application for renewal license, see § 83-39-3(8)(b).

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 77.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-19. Appeals.

Any person aggrieved by an act of the commissioner under the provisions of this chapter may appeal therefrom, within thirty (30) days after receipt of notice thereof, to the circuit court of the county in which is located the domicile of said person by writ of certiorari, upon giving bond with the surety or sureties and in such penalty as shall be approved by the circuit clerk of said county, conditioned that such appellant will pay all costs of the appeal in the event such appeal is not prosecuted successfully. The said circuit court shall have the opportunity and jurisdiction to hear said appeal and render its decision in regard thereto, either in termtime or vacation time.

Actions taken by the commissioner or department in suspending a license, registration or permit when required by Section 93-11-157 or 93-11-163 are not actions from which an appeal may be taken under this section. Any appeal of a suspension of a license, registration or permit that is required by Section 93-11-157 or 93-11-163 shall be taken in accordance with the appeal procedure specified in Section 93-11-157 or 93-11-163, as the case may be, rather than the procedure specified in this section.

**SOURCES: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1996, ch. 507, § 90, eff from and after July 1, 1996.**

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 68.

## § 83-39-21. Judicial proceeding in lieu of departmental hearing.

The commissioner, in his discretion, in lieu of the hearing provided for in Section 83-39-17, may file a petition to suspend or revoke any license authorized hereunder in a court of competent jurisdiction of the county or district in which the alleged offense occurred. In such cases, subpoenas may be issued for witnesses, and mileage and witness fees paid by the defendant, if found guilty. If costs cannot be made and collected from the defendant, the costs shall be assessed against the qualification bond if the defendant is a professional bail agent, and if the defendant is a soliciting bail agent or bail enforcement agent, against the employing professional bail agent or his qualification bond.

Any court of competent jurisdiction within this state may suspend or revoke the license of any person licensed under this chapter for any of the following reasons:

(a) Misappropriation, conversion or unlawful withholding of monies belonging to insured principals or others and received in the conduct of business under a license provided by this chapter.

(b) Fraudulent or dishonest practices in the conduct of the business under a license provided by this chapter.

(c) The commission of any act which would prohibit or restrict the licensee from holding a license under this chapter.

The court which suspends or revokes a license under the terms of this chapter, or the clerk thereof, shall promptly furnish the commissioner a copy of the suspension or revocation order.

**SOURCES: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 10, eff from and after July 1, 1994.**

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 67.

## § 83-39-23. Notice to sheriff and judicial officials.

No sheriff or other official shall accept bond from a professional bail agent unless the bail agent is licensed under this chapter and unless the bail agent shall exhibit to the court a valid certificate or license issued by the department, and the license of the bail agent shall not have been suspended or revoked. The department, upon request, may furnish to any sheriff, district, circuit court or municipal judge additional information which would appropriately identify the duly licensed professional bail agent and insurers whose operation in the writing of bail is covered by this chapter.

**SOURCES: Codes, 1942, § 8745-07; Laws, 1968, ch. 341, § 7; Laws, 1994, ch. 495, § 11, eff from and after July 1, 1994.**

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

### JUDICIAL DECISIONS

**1. In general.**

Company whose name was forged on bail bonds by an unauthorized person will not be subjected to forfeiture judgments on bonds, and the company is not estopped to assert the truth in view of the fact that it had no knowledge of the forgery or that certain powers of attorney issued to a deceased agent came into the possession of a person not its agent, particularly where the deputy sheriff who accepted the bonds made no investigation as to the authority of the person executing and tendering them. Resolute Ins. Co. v. State, 290 So. 2d 599 (Miss. 1974).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-25. Maximum premium, commission or fee; processing fee; holding collateral to insure payment of premium or indemnify for losses.

(1) A professional bail agent or his agent shall charge and collect for his premium, commission, or fee an amount of ten percent (10%) of the amount of bail per bond posted by him, or One Hundred Dollars ($100.00), whichever is

greater, except on a bond on a defendant who is charged with a capital offense, or on a defendant who resides outside the State of Mississippi, in which case the premium, commission or fee shall be fifteen percent (15%) of the amount of bail, per bond posted by him, or One Hundred Dollars ($100.00), whichever is greater.

(2) A professional bail agent or his agent shall also charge an additional Fifty Dollars ($50.00) processing fee on each bond issued by him.

(3) Nothing herein shall prohibit a professional bail agent or his agent from holding collateral or taking a security interest in collateral for the purpose of insuring the payment of the premium of the bond posted or indemnifying the professional bail agent for losses incurred due to a forfeiture of a bond or the costs of apprehension and surrender of the principal.

(4) Any fee charged by a professional bail agent or his agent for court-approved electronic monitoring or drug testing shall not be considered part of the premium, commission or fee charged under this section.

**SOURCES: Codes, 1942, § 8745-08; Laws, 1968, ch. 341, § 8; Laws, 1994, ch. 495, § 12; Laws, 1994, ch. 634, § 1; Laws, 2001, ch. 350, § 1; Laws, 2007, ch. 501, § 2; Laws, 2009, ch. 520, § 1; Laws, 2011, ch. 463, § 6, eff from and after July 1, 2011.**

**Amendment Notes** — The 2009 amendment substituted "One Hundred Dollars ($100.00)" for "Fifty Dollars ($50.00)" both times it appears in (1); deleted former (2), which related to a fee charged for expenses resulting from a bond of $1,000.00 or less when the bail agent had to travel outside the county in which he does business; redesignated former (3) and (4) as present (2) and (3); and substituted "Fifty Dollars ($50.00)" for "Twenty-five Dollars ($25.00)" in (2).

The 2011 amendment added (4).

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Limits on fee as specified in this section not to include fee imposed on each bond taken by bondsmen, see § 83-39-31.

### ATTORNEY GENERAL OPINIONS

The only charges a professional bail agent or his agent may charge are set forth in Section 83-39-25. Champion, Sept. 23, 2005, A.G. Op. 05-0387.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 76.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-27. Prohibited activities.

It is unlawful for a licensee to engage in any of the following activities:

(a) Specify, suggest or advise the employment of any particular attorney to represent his principal.

(b) Pay a fee or rebate or give or promise to give anything of value to a jailer, policeman, peace officer, clerk, deputy clerk, any other employee of any court, district attorney or any of his employees or any person who has power to arrest or to hold any person in custody.

(c) Pay a fee or rebate or give anything of value to an attorney in bail bond matters, except in defense of any act on a bond, or as counsel to represent such bail agent, his agent or employees.

(d) Pay a fee or rebate or give or promise to give anything of value to the person on whose bond he is surety.

(e) Pay a fee or rebate or give or promise to give anything of value to any person, other than a soliciting bail agent, for the purpose of procuring a bail bond.

(f) Accept anything of value from a person on whose bond he is surety, or from others on behalf of such person, except the fee or premium on the bond, but the bail agent may accept collateral security or other indemnity.

(g) Coerce, suggest, aid and abet, offer promise of favor or threaten any person on whose bond he is surety or offers to become surety, to induce that person to commit any crime.

(h) Give legal advice or a legal opinion in any form.

**SOURCES: Codes, 1942, § 8745-09; Laws, 1968, ch. 341, § 9; Laws, 1994, ch. 495, § 13; Laws, 2001, ch. 320, § 1; brought forward without change, Laws, 2010, ch. 466, § 5; Laws, 2011, ch. 463, § 7, eff from and after July 1, 2011.**

**Amendment Notes —** The 2010 amendment brought this section forward without change.

The 2011 amendment added (e); and redesignated former (e) through (g) as present (f) through (h).

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

## ATTORNEY GENERAL OPINIONS

Where justice court bond is $10,000 and defendant has to pay ten percent or $1,000 dollars to bondsman to get bonded out, bondsman's taking of $500 down and $100 per week is legal, since nothing in Miss. Code Section 83-39-27 prohibits this activity. Ferguson, June 9, 1993, A.G. Op. #93-0331.

Subsection (d) is not violated by a bondsman taking credit from a defendant in order to post bail. Foretich, August 10, 1998, A.G. Op. #98-0455.

## RESEARCH REFERENCES

**ALR.** Failure to appear, and the like, resulting in forfeiture or conditional forfeiture of bail, as affecting right to second admission to bail in same noncapital criminal case. 29 A.L.R.2d 945.

Bail jumping after conviction, failure to surrender or to appear for sentencing, and the like, as contempt. 34 A.L.R.2d 1100.

Validity of statute abolishing commercial bail bond business. 19 A.L.R.4th 355.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 75.

**CJS.** 44 C.J.S., Insurance § 138.

## § 83-39-29. Penalties.

(1) The department may provide information to the district attorney in the district in which a professional bail agent, a soliciting bail agent or bail enforcement agent is domiciled so that proper legal action may be pursued against any licensee who is alleged to have violated any provision of Chapter 39 of Title 83. Such licensee is guilty of a misdemeanor and shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both. Any insurer violating any provision of Chapter 39 of Title 83 may be fined in an amount not to exceed Fifty Thousand Dollars ($50,000.00).

(2) Any person who acts or attempts to solicit, write or present a bail bond as a professional bail agent, soliciting bail agent, or bail enforcement agent as defined in this chapter and who is not licensed under this chapter is guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both.

(3) Any person who acts or attempts to act, represents himself to be, or impersonates a professional bail agent, a soliciting bail agent or a bail enforcement agent as defined in this chapter by attempting to arrest or detaining any person, and who is not licensed under this chapter, is guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than Five Thousand Dollars ($5,000.00), imprisonment for not more than one (1) year, or both.

(4) A bail agent, bail enforcement agent or bail enforcement agent from another state shall report to the sheriff's department of the county in which he is attempting to locate a fugitive prior to beginning to look for the fugitive to prove his licensing and legal right to the fugitive. Failure to prove licensing shall be an offense punishable by a fine not to exceed One Thousand Dollars ($1,000.00).

(5) Any person charged with a criminal violation who has obtained his release from custody by having a professional bail agent, insurer, agent of a bail agent or insurer, or any person other than himself furnish his bail bond and who fails to appear in court, at the time and place ordered by the court, is guilty of "bond jumping" and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred returning the defendant to court.

(6) Any person who knowingly and intentionally aids and abets any person in the commission of the offense of bond jumping, whether the person committing the principal offense is actually convicted, shall be guilty of aiding and abetting bond jumping and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00) or imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred in returning the defendant to court. Any person who is convicted of aiding and abetting shall be jointly and severally

liable for payment of restitution for reasonable expenses incurred in returning the defendant to court.

(7) Any bail agent who is prejudiced or injured by the commission of any of the offenses set forth in this section shall have standing to file a complaint alleging the commission of the offense or offenses.

**SOURCES: Codes, 1942, §§ 8745-09, 8745-10; Laws, 1968, ch. 341, §§ 9, 10; Laws, 1994, ch. 495, § 14; Laws, 1994, ch. 634, § 2; Laws, 2003, ch. 466, § 1; Laws, 2005, ch. 412, § 1; Laws, 2009, ch. 520, § 2; brought forward without change, Laws, 2010, ch. 466, § 6, eff from and after July 1, 2010.**

**Amendment Notes** — The 2009 amendment, substituted "shall be guilty of...returning the defendant to court" for "shall be guilty of bond jumping to the same degree as the person so aided and abetted and shall be punished accordingly" in (6).

The 2010 amendment brought this section forward without change.

**Cross References** — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

### ATTORNEY GENERAL OPINIONS

A defendant who has been released on his own recognizance and fails to appear in court for his hearing does not meet the requisite elements to be charged with bondjumping. Busby, July 23, 2004, A.G. Op. 04-0316.

### RESEARCH REFERENCES

**ALR.** State statutes making default on bail a separate criminal offense. 63 A.L.R.4th 1064.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 69.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

**CJS.** 44 C.J.S., Insurance § 139.

## § 83-39-31. Fee on appearance bonds and recognizances; additional assessment on bail bonds to be deposited into Victims of Domestic Violence Fund.

(1) Upon every defendant charged with a criminal offense who posts a cash bail bond, a surety bail bond, a property bail bond or a guaranteed arrest bond certificate conditioned for his appearance at trial, there is imposed a fee equal to two percent (2%) of the face value of each bond or Twenty Dollars ($20.00), whichever is greater, to be collected by the clerk of the court when the defendant appears in court for final adjudication or at the time the defendant posts cash bond unless subsection (4) applies.

(2) Upon each defendant charged with a criminal offense who is released on his own recognizance, who deposits his driver's license in lieu of bail, or who is released after arrest on written promise to appear, there is imposed a fee of

Twenty Dollars ($20.00) to be collected by the clerk of the court when the defendant appears in court for final adjudication unless subsection (4) applies.

(3) Upon each defendant convicted of a criminal offense who appeals his conviction and posts a bond conditioned for his appearance, there is imposed a fee equal to two percent (2%) of the face value of each bond or Twenty Dollars ($20.00), whichever is greater. If such defendant is released on his own recognizance pending his appeal, there is imposed a fee of Twenty Dollars ($20.00). The fee imposed by this subsection shall be imposed and shall be collected by the clerk of the court when the defendant posts a bond unless subsection (4) applies.

(4) If a defendant is found to be not guilty or if the charges against a defendant are dismissed, or if the prosecutor enters a nolle prosequi in the defendant's case or retires the defendant's case to the file, or if the defendant's conviction is reversed on appeal, the fees imposed pursuant to subsections (1), (2), (3) and (7) shall not be imposed.

(5) The State Auditor shall establish by regulation procedures providing for the timely collection, deposit, accounting and, where applicable, refund of the fees imposed by this section. The Auditor shall provide in the regulations for certification of eligibility for refunds and may require the defendant seeking a refund to submit a verified copy of a court order or abstract by which the defendant is entitled to a refund.

(6) It shall be the duty of the clerk or any officer of the court authorized to take bonds or recognizances to promptly collect, at the time such bonds or recognizances are received or taken, all fees imposed pursuant to this section. In all cases, the clerk or officer of the court shall deposit all fees so collected with the State Treasurer, pursuant to appropriate procedures established by the State Auditor, for deposit into the State General Fund.

(7) In addition to the fees imposed by this section, there shall be an assessment of Ten Dollars ($10.00) imposed upon every criminal defendant charged with a criminal offense who posts a cash bail bond, a surety bail bond, a property bail bond or a guaranteed arrest bond to be collected by the clerk of the court and deposited in the Victims of Domestic Violence Fund created by Section 93-21-117, unless subsection (4) applies.

**SOURCES: Laws, 1990, ch. 329, § 2; Laws, 1994, ch. 495, § 15; Laws, 1995, ch. 371, § 1; Laws, 1999, ch. 364, § 1; Laws, 2009, ch. 463, § 1; Laws, 2011, ch. 339, § 1, eff from and after passage (approved Mar. 14, 2011.)**

**Editor's Note —** Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor", and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration".

**Amendment Notes —** The 2009 amendment substituted "subsections (1), (2), (3) and (7)" for "subsections (1), (2) and (3)" in (4); and added (7).

The 2011 amendment added "unless subsection (4) applies" at the end of (7).

**Cross References —** Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

## ATTORNEY GENERAL OPINIONS

Where defendant is not adjudicated guilty or there is successful pretrial diversion, fees imposed may be returned to defendant pursuant to Section 83-39-31(5). Brown, July 8, 1993, A.G. Op. #93-0283.

Bond fee demanded by 83-39-31(4) is applicable to appearance bond posted by criminal defendant appealing conviction from circuit court to state supreme court. Dyson, August 5, 1993, A.G. Op. #93-0439.

Under this section, the clerk must keep a list of the bonds posted and the cases wherein the State has failed to obtain a conviction, in which cases the fees paid are subject to refund. However, it does not require a justice court clerk to prepare a weekly list of names for the benefit of a private citizen or a business i.e. bail bondsman. Corviss, February 16, 1995, A.G. Op. #95-0074.

A defendant released by a justice court judge on a recognizance bond does not have to pay a bond fee until he/she appears in court for final adjudication. Bush, Dec. 5, 1997, A.G. Op. #97-0761.

There is no authority to charge a $25.00 bail bond fee on DUI's and misdemeanors; the statute provides for a fee equal to two percent of the face value of a bond or $20.00, whichever is greater, for every defendant charged with a criminal offense who posts a bond; this fee should be imposed for DUI's and misdemeanors, but is not to be collected if the defendant is found not guilty or the charges are dismissed. Barnett, May 19, 2000, A.G. Op. #2000-0272.

Based on subsection (4), no bond fee should be imposed if the charges against the defendant are dismissed or remanded. Green, June 30, 2000, A.G. Op. #2000-0337.

Either two percent of the face value of each cash bond or $20.00, whichever is greater, must be collected at the time a defendant posts a cash bond by the officer who takes the bond, and the clerk of the court must collect the bond fee that may be due for any other type of bond, i.e., surety bond, property bond, etc. Thomas, Mar. 29, 2002, A.G. Op. #02-0148.

The 2%/$20 fee shall not be imposed and therefore not collected from individuals ordered into the Eighth Judicial District Drug Court. Henderson, Sept. 30, 2005, A.G. Op. 05-0430.

Payments of the fine to the clerk constitutes an appearance and final adjudication for purposes of collecting the required $ 20.00 fee. Lexington Municipal Judge, Sept. 5, 2006, A.G. Op. 06-0412.

# CHAPTER 41

## Hospital and Medical Service Associations and Contracts

Article 1. Hospital Service Associations. [Repealed]
Article 3. Nonprofit Hospital, Medical, and Surgical Service Corporations. [Repealed]
Article 5. Provisions Common to Hospital, Medical, or Surgical Insurance ........ 83-41-201
Article 7. Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act ........ 83-41-301
Article 9. Patient Protection Act of 1995 ........ 83-41-401

### ARTICLE 1.

### HOSPITAL SERVICE ASSOCIATIONS [REPEALED].

### §§ 83-41-1 through 83-41-19. Repealed.

Repealed by Laws, 1997, ch. 307, § 1, eff from and after July 1, 1997.

§ 83-41-1 through § 83-41-19. [Codes, 1942, §§ 5606-5615; Laws, 1936, ch. 177]

**Editor's Note —** Former §§ 83-41-1 through 83-41-19 provided for the organization and regulation of hospital and medical service associations by the Commissioner of Insurance.

### ARTICLE 3.

### NONPROFIT HOSPITAL, MEDICAL, AND SURGICAL SERVICE CORPORATIONS [REPEALED].

### §§ 83-41-101 through 83-41-131. Repealed.

Repealed by Laws, 1997, ch. 307, § 2, eff from and after July 1, 1997.

§ 83-41-101 through § 83-41-123. [Codes, 1942, §§ 5615-01-5615-12; Laws, 1948, ch. 349, §§ 1-12]

§ 83-41-125. [Codes, 1942, § 5615-13; Laws, 1948, ch. 349, § 13; Laws, 1994, ch. 422, § 4]

§ 83-41-127. [Codes, 1942, § 5615-14; Laws, 1948, ch. 349, § 14; Laws, 1956, ch. 341; Laws, 1978, ch. 441, § 8]

§ 83-41-129. [Codes, 1942, § 5615-15; Laws, 1948, ch. 349, § 15]

§ 83-41-131. [Codes, 1942, § 5615-16; Laws, 1948, ch. 349, § 16; Laws, 1994, ch. 422, § 5]

**Editor's Note —** Former §§ 83-41-101 through 83-41-123 provided for the organization and regulation of nonprofit hospital, medical and surgical service corporations by the Commissioner of Insurance.

Former § 83-41-125 directed that any dissolution, liquidation supervision or rehabilitation of a corporation be conducted by the Commissioner of Insurance.

Former § 83-41-127 provided that charitable and benevolent corporations be exempt from taxation.

Former § 83-41-129 provided for the conversion of existing service corporations into nonprofit corporations.

Former § 83-41-131 provided for the conversion of nonprofit hospital, medical and surgical corporations to mutual insurance companies.

## Article 5.

## Provisions Common to Hospital, Medical, or Surgical Insurance.

Sec.
83-41-201. Notice to insured required for cancellation.
83-41-203. Beneficiaries' freedom of choice of practitioner in performance of visual service; optometrists.
83-41-205. Individual hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.
83-41-207. Group hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.
83-41-209. Beneficiaries' freedom of choice of practitioner in performance of dental services.
83-41-211. Beneficiaries' freedom of choice of practitioner in treatment of mental, nervous or emotional disorders; psychologist, professional counselor or clinical social worker.
83-41-213. Right of insureds or other beneficiaries to be reimbursed for services performed by physicians or nurse practitioners within lawful scope of their practice.
83-41-214. Payment by third parties of certified nurse practitioners.
83-41-215. Right of beneficiary or insured to reimbursement for services performed by chiropractor; freedom of choice of practitioner and place of services.
83-41-217. Direct access to obstetricians/gynecologists to be allowed; status as primary care physicians.
83-41-219. Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Note for effective date and applicability].

## § 83-41-201. Notice to insured required for cancellation.

Whenever any policy of hospital, medical, or surgical insurance issued or renewed after June 11, 1964, shall have been in continuous full force and effect for at least four (4) years with all premiums paid thereon, no insurance company chartered or authorized to do business in the State of Mississippi, or doing business herein, shall be permitted to cancel or refuse to renew its policy of hospital, medical, or surgical insurance issued after said date to a resident citizen of the State of Mississippi without first giving written notice to the insured; and the cancellation or refusal to renew shall not be effective until one (1) year from and after the date of the receipt of such written notice as shown by certified mail sent with return receipt requested. Any effort to cancel a policy of hospital, medical, or surgical insurance or any refusal to accept premiums on such a policy contrary to the provisions of this section shall be ineffective if the policyholder makes an offer to pay the premium as and when due, or within the grace period, and one (1) offer shall be all that is necessary if that offer is refused by the company.

The provisions of this section shall not apply to group and blanket insurance, nor to any policy in which the insurer does not reserve the right to refuse renewal on an individual basis. The provisions of this section shall not prevent cancellation of any hospital, medical, or surgical insurance policy because of duplicate coverage providing for payment of benefits in excess of hospital, medical, nursing, or drug expenses actually incurred.

**SOURCES: Codes, 1942, § 5615-31; Laws, 1964, ch. 473, § 1, eff from and after passage (approved June 11, 1964).**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the first sentence of the last paragraph. The word "insuror" was changed to "insurer." The Joint Committee ratified the correction at its May 20, 1998, meeting.

**Cross References** — Required provisions of accident and sickness policy, see § 83-9-5.

### JUDICIAL DECISIONS

**1. In general.**

Allegations of a bill of complaint charging improper premium rate increases in health and accident policies leading to the increased payments by some policyholders and to policy terminations by others, were not within the ambit of this section [Code 1942 § 5615-31] and did not properly charge a violation of it. Gandy v. Reserve Life Ins. Co., 279 So. 2d 648 (Miss. 1973).

### RESEARCH REFERENCES

**ALR.** Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness. 66 A.L.R.3d 1205.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 433 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 184 (answer containing defense of cancellation of policy by insurer prior to loss-notice of cancellation mailed and unearned premium refunded).

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 185 (answer containing defense of cancellation policy by insurer prior to loss-policy surrendered to insurer after notice of cancellation and return of unearned premiums).

**CJS.** 45 C.J.S., Insurance §§ 674 et seq.

## § 83-41-203. Beneficiaries' freedom of choice of practitioner in performance of visual service; optometrists.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any visual service which is within the lawful scope of practice of a duly licensed optometrist as defined in Section 73-19-1, Mississippi Code of 1972, the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed optometrist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly licensed optometrists shall be entitled to participate in such policies, plans, or contracts providing for visual services, as authorized by Sections 73-19-1 and 43-3-67, Mississippi Code of 1972, to the same extent as duly licensed physicians.

**SOURCES: Codes, 1942, § 5615-41; Laws, 1966, ch. 527, § 1, eff from and after passage (approved February 23, 1966).**

## RESEARCH REFERENCES

**Am Jur.** 44A Am. Jur. 2d, Insurance § 1591.

## § 83-41-205. Individual hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.

Any individual hospital or medical service plan contract or any individual hospital or medical expense insurance policy delivered or issued for delivery in this state after September 12, 1972, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract or policy, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of having an intellectual disability or a physical disability, and (b) chiefly dependent upon the subscriber or policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital or medical service plan corporation or insurer by the subscriber or policyholder within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the corporation or insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Any insurer or hospital service plan corporation continuing dependent coverage beyond the limiting age for dependent children as prescribed by this section, shall have the right to charge the standard adult premium for such coverage.

**SOURCES: Codes, 1942, §§ 5615-51, 5615-53; Laws, 1972, ch. 499, §§ 1, 3; Laws, 2010, ch. 476, § 76, eff from and after passage (approved Apr. 1, 2010.)**

**Amendment Notes —** The 2010 amendment substituted "having an intellectual disability or a physical disability" for "mental retardation or physical handicap."

## § 83-41-207. Group hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.

Any group hospital or medical service plan contract or any group hospital or medical expense insurance policy delivered or issued for delivery in this state after September 12, 1972, which provides that coverage of a dependent child of an employee, insured party, or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the contract or policy, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of having an intellectual disability or a physical disability, and (b) chiefly dependent upon the employee, insured party, or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital or medical service plan corporation or insurer by the employee, insured party, or member within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the corporation or insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Any insurer or hospital service plan corporation continuing dependent coverage beyond the limiting age for dependent children as prescribed by this section, shall have the right to charge the standard adult premium for such coverage.

**SOURCES: Codes, 1942, §§ 5615-52, 5615-53; Laws, 1972, ch. 499, §§ 2, 3; Laws, 2010, ch. 476, § 77, eff from and after passage (approved Apr. 1, 2010.)**

**Amendment Notes** — The 2010 amendment substituted "having an intellectual disability or a physical disability" for "mental retardation or physical handicap" in the first paragraph.

## § 83-41-209. Beneficiaries' freedom of choice of practitioner in performance of dental services.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed dentist, as defined by the laws of the State of Mississippi, the insured, or other person entitled to benefits under such policy, shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed dentist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract; duly licensed dentists shall be entitled to participate in such policies, plans or contracts providing for dental services, as authorized by the laws of the State of Mississippi.

**SOURCES: Laws, 1974, ch. 406, eff from and after passage (approved March 25, 1974).**

**Cross References** — Practice of dentistry or dental hygiene generally, see §§ 73-9-1 et seq.

Definition of the term "dentists", see § 73-9-3.

Nonprofit dental service corporations, see §§ 83-43-1 et seq.

## § 83-41-211. Beneficiaries' freedom of choice of practitioner in treatment of mental, nervous or emotional disorders; psychologist, professional counselor or clinical social worker.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any diagnosis and treatment of mental, nervous or emotional disorders only which are within the lawful scope of practice of a duly licensed psychologist as defined in Section 73-31-3, within the lawful scope of practice of a duly licensed professional counselor as defined in Section 73-30-3, within the lawful scope of practice of a duly licensed clinical social worker as defined in Section 73-53-3, or within the lawful scope of practice of a duly licensed marriage and family therapist as defined in Section 73-54-5, the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed psychologist, by a duly licensed professional counselor, by a duly licensed clinical social worker or by a duly licensed marriage and family therapist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly licensed psychologists shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-31-3. A duly licensed professional counselor shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-30-3. A duly licensed clinical social worker shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-53-3. A duly licensed marriage and family therapist shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-54-5 et seq.

The addition of marriage and family therapists as providers herein is intended to only allow them to treat mental, nervous or emotional disorders as treated by other providers, to the extent that marriage and family therapists are qualified to treat such disorders. Notwithstanding anything in this section to the contrary, the scope or definition of mental, nervous or emotional disorders shall remain the same and shall not be expanded by the addition of marriage and family therapists as allowable providers.

**SOURCES: Laws, 1974, ch. 514; Laws, 1992, ch. 586, § 1; reenacted and amended, 1994, ch. 327, § 1; reenacted and amended, Laws, 2005, ch. 493, § 1; Laws, 2008, ch. 318, § 1, eff from and after July 1, 2008.**

## RESEARCH REFERENCES

**ALR.** What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

## § 83-41-213. Right of insureds or other beneficiaries to be reimbursed for services performed by physicians or nurse practitioners within lawful scope of their practice.

From and after January 1, 1999, whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued, delivered, administered, continued or renewed in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly certified nurse practitioner as provided for by rules and regulations implemented by the Mississippi Board of Nursing under Section 73-15-5(2), the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly certified nurse practitioner, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly certified nurse practitioners shall be entitled to participate in such policies, plans or contracts providing for the services of nurse practitioners, as authorized by the rules and regulations implemented by the Mississippi Board of Nursing under Section 73-15-5(2). Reimbursement shall be based on services rendered by a duly certified nurse practitioner.

It is the intent of the Legislature by this section to provide for increased access of health delivery services to the underserved.

**SOURCES: Laws, 1979, ch. 469; reenacted, 1982, ch. 357, § 1; reenacted, 1984, ch. 330, § 1; reenacted 1988, ch. 422, § 1; reenacted 1988, ch. 412, § 1; Laws, 1999, ch. 326, § 2; Laws, 2009, ch. 474, § 3; Laws, 2010, ch. 315, § 3, eff from and after July 1, 2010.**

**Editor's Note** — Section 1 of Chapter 412, Laws of 1988, reenacted Section 83-41-213, effective from and after July 1, 1988 (approved by the Governor on April 23, 1988). Subsequently, Section 1, Chapter 422, Laws of 1988, also reenacted Section 83-41-213, effective upon passage, (approved by the Governor on April 23, 1988). The amendatory language in Chapters 412 and 422 is identical, and, by direction of the Attorney General's Office of Mississippi, the effective date of July 1, 1988, has been inserted.

**Amendment Notes** — The 2009 amendment in the first version, deleted "working under the supervision of a duly licensed physician" preceding "nurse practitioner" throughout the first paragraph; and rewrote the second paragraph.

The 2010 amendment rewrote the section.

### ATTORNEY GENERAL OPINIONS

Section 83-41-213(2) mandates that any all rules and/or regulations promulgated after March 28, 1995, relating to any activity of a nurse practitioner beyond the statutory definition of nursing must be adopted in identical form by both the Mississippi State Board of Medical Licensure and the Mississippi Board of Nursing, encompassed in orders spread upon the minutes of each board, and that such joint promulgation must comply with the provisions of the Mississippi Administrative Procedures Law, codified at §§ 25-43-1, et seq.; further, the Mississippi Board of Nursing may not adopt enforceable rules or regulations that impact the practice of nurse practitioners without the joint consent of the Mississippi State Board of Medical Licensure. Stevens, June 19, 1998, A.G. Op. #98-0354.

Any rules or regulations that impact the practice of nurse practitioners are to be jointly promulgated by the Mississippi Board of Nursing and the State Board of Medical Licensure. Perkins, Mar. 31, 2003, A.G. Op. #03-0060.

### RESEARCH REFERENCES

**ALR.** What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

**Law Reviews.** 1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813, December 1979.

## § 83-41-214. Payment by third parties of certified nurse practitioners.

A policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a duly certified nurse practitioner and performed within the scope of the license of the certified nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery. The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a certified nurse practitioner if the coverage is rejected for all providers of similar services. A policy or contract subject to this section shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than the restriction already imposed by law. This section applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this on or after July 1, 1999, and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, whichever is later. This section does not apply to policyholders or subscribers eligible for coverage under Title XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan. For the purposes of this section, third-party payment or prepayment includes an individual or group health care service contract, an individual or group health maintenance organization contract, or a preferred provider organization contract. Nothing in this section shall be interpreted to require an individual or group health maintenance organization, or a preferred provider organization to provide payment or prepayment for services provided by a certified nurse practitioner unless the certified nurse practitioner or the certified nurse practitioner's collaborating physician has entered into a contract or other agreement to provide services with the individual or group health maintenance organization or the preferred provider organization or arrangement.

**SOURCES: Laws, 1999, ch. 326, § 1, eff from and after July 1, 1999.**

**Federal Aspects** — Title XVIII of the Social Security Act, see 42 USCS §§ 1395 et seq.

## § 83-41-215. Right of beneficiary or insured to reimbursement for services performed by chiropractor; freedom of choice of practitioner and place of services.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor as defined in Section 73-6-1, Mississippi Code of 1972, then such service may be performed by a duly licensed chiropractor, and the insured or other person entitled to benefits under such policy, plan or contract shall be entitled to reimbursement for such services. The insured shall have the right to choose the place where the service is to be performed as well as the chiropractor to perform such service, provided that such service shall be performed in the chiropractor's office, clinic or regular place of business.

**SOURCES: Laws, 1980, ch. 369, eff from and after passage (approved April 24, 1980).**

**Cross References** — Accident and health insurance policy provisions, generally, see § 83-9-5.

### JUDICIAL DECISIONS

**1. In general.**

Chiropractor claiming tortious interference and bad faith has standing to sue under § 83-41-215 for compensation; § 83-41-215 is not applicable to workers' compensation carrier, because §§ 71-3-9 and 71-3-15 clearly exclude chiropractic treatment unless it is approved by employer or carrier. Norville v. Commercial Union Ins. Co., 690 F. Supp. 558 (S.D. Miss. 1988), aff'd, 866 F.2d 1419 (5th Cir. 1989).

Claim by chiropractor that termination by workers' compensation insurance carrier of payments for chiropractic treatment state claims for tortious interference and bad faith, and are couched in terms so that they present case for plaintiff rather than claim for workers' compensation benefits, such that plaintiff has standing to sue under claims he has set forth, however, since workers' compensation laws specifically exclude chiropractic treatment as generally compensable, plaintiff does not have cause of action arising under § 83-41-215. Norville v. Commercial Union Ins. Co., 690 F. Supp. 558 (S.D. Miss. 1988), aff'd, 866 F.2d 1419 (5th Cir. 1989).

Section 83-41-215, which provides in part that an insured shall have the right to choose a chiropractor and the place where chiropractic services are to be performed, does not prohibit an insurance company from drafting its medical payment clause to exclude coverage for chiropractic care, to include coverage for all chiropractic care, or to limit its coverage to only some chiropractic services. However, any company binding itself to cover chiropractic services brings itself under the dictates of the statute's mandatory freedom of choice provision. State Farm Mut. Auto. Ins. Co. v. Gregg, 526 So. 2d 554 (Miss. 1988).

The term "medical" in a medical payment provision of an insurance policy included healing arts in addition to the practice of medicine where the provision stated that coverage was provided for "necessary medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, and funeral services, eyeglasses, hearing aids, and prosthetic devices." As used in the above-quoted portion of the provision, "medical" includes services or health care in addition to services provided by a physician. Thus, the insurance company was required to pay for reasonably necessary expenses for chiropractic care rendered to alleviate the effects of accidental bodily injury. State Farm Mut. Auto. Ins. Co. v. Gregg, 526 So. 2d 554 (Miss. 1988).

### RESEARCH REFERENCES

**ALR.** What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

**Am Jur.** 44A Am. Jur. 2d, Insurance § 1590.

**CJS.** 45 C.J.S., Insurance § 1416.

## § 83-41-217. Direct access to obstetricians/gynecologists to be allowed; status as primary care physicians.

Any health care service plan contract that provides hospital, outpatient, medical or surgical coverage that is issued, amended, delivered or renewed in this state shall include obstetricians/gynecologists as primary care physicians and allow direct access to obstetricians/gynecologists by female patients if the obstetrician/gynecologist otherwise meets the policy or contract requirements.

**SOURCES: Laws, 1995, ch. 514, § 1, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 15, 28.

44 Am. Jur. 2d, Insurance § 1486.

**CJS.** 44 C.J.S., Insurance §§ 392 et seq.

## § 83-41-219. Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Note for effective date and applicability].

(1) If any health insurance issuer or other health insurance benefit payer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the

claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.

(2) If any health insurance issuer or other health insurance benefit payer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim.

(3) Nothing in this section shall apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person.

(4) Nothing in this section shall apply to an audit of a pharmacy as provided in Section 73-21-175 et seq., nor to claims submitted by providers for reimbursement under the Mississippi Medicaid Program.

**SOURCES: Laws, 2010, ch. 393, § 1, eff from and after July 1, 2010.**

**Editor's Note** — Laws of 2010, ch. 393, § 2 provides:

"SECTION 2. This act shall take effect and be in force from and after July 1, 2010, and shall apply to health care claims submitted for payment on or after that date."

**Cross References** — Mississippi Medicaid generally, see §§ 43-13-101 through 43-13-147.

## ARTICLE 7.

## HEALTH MAINTENANCE ORGANIZATION, PREFERRED PROVIDER ORGANIZATION AND OTHER PREPAID HEALTH BENEFIT PLANS PROTECTION ACT.

| SEC. | |
|---|---|
| 83-41-301. | Short title. |
| 83-41-303. | Definitions. |
| 83-41-305. | Requirement of certificate of authority for establishment and operation of health maintenance organization; filing, form and contents of application for certificate and attachments; qualification of foreign health maintenance organizations; effect of denial of certificate; rules and regulations. |
| 83-41-307. | Transmission of copies of application for certificate of authority to State Health Officer; duties of State Health Officer; grant or denial of certificate of authority. |
| 83-41-309. | Powers of health maintenance organization generally; notice of exercise of powers affecting financial condition of organization. |
| 83-41-311. | Bonds or insurance for directors, officers, employees, partners and contractors. |
| 83-41-313. | Quality assurance procedures, programs and activities; maintenance and examination of patient records. |
| 83-41-315. | Filing, contents and approval of group and individual contracts and evidence of coverage. |
| 83-41-317. | Filing of annual reports, financial statements, etc. |
| 83-41-319. | Provision of information and notices to subscribers. |
| 83-41-321. | Grievance procedures. |

83-41-323. Funds.
83-41-325. Minimum net worth requirement; deposits generally; computation of liabilities; contracts between health maintenance organizations and participating providers of services; insolvency plans.
83-41-327. Uncovered expenditures insolvency deposits.
83-41-329. Proceedings upon insolvency of health maintenance organization; terms and conditions of replacement coverage.
83-41-331. Premium rates.
83-41-333. Rules and regulations generally; exemptions from certification requirement.
83-41-335. Operation of health maintenance organizations by insurance companies and medical service corporations.
83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.
83-41-339. Grounds and procedure for revocation, suspension or denial of certificate of authority; administrative penalty generally; correction of deficiencies in net worth; proceedings upon suspension or revocation of certificate of authority; appeals.
83-41-341. Rehabilitation, liquidation or administrative supervision of health maintenance organizations.
83-41-343. Remedies for correction of financial conditions of health maintenance organizations deemed hazardous to enrollees, creditors, or general public and violations of article.
83-41-345. Adoption of rules and regulations.
83-41-347. Fees.
83-41-349. Imposition of administrative penalties; informal proceedings for investigation and correction or prevention of violations; cease and desist orders.
83-41-351. Solicitation of enrollees.
83-41-353. Documents deemed public documents.
83-41-355. Confidentiality of data or information; claims of privilege; civil liability of members of health review committees; discovery of information considered by and records of health review committees; access to treatment records, etc., of enrollees.
83-41-357. Contracting authority of State Health Officer.
83-41-359. Acquisitions, mergers and consolidations of health maintenance organizations.
83-41-361. Adoption of coordination of benefits provisions.
83-41-363. Proceedings upon insolvency of health maintenance organization.
83-41-365. Contracting authority of commissioner.

## § 83-41-301. Short title.

This article may be cited as the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act.

**SOURCES: Laws, 1995, ch. 613, § 1, eff from and after July 1, 1995.**

**Cross References** — Health maintenance organizations to comply with §§ 83-41-401 et seq. certification requirements, see § 83-41-411.

Applicability of article to Division of Medicaid in Office of Governor, see § 83-41-415.

## RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

## § 83-41-303. Definitions.

(a) "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and includes but is not limited to mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment for the purpose of preventing, alleviating, curing or healing human illness or physical disability.

(b) "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. Capitated basis includes the cost associated with operating staff model facilities.

(c) "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, fraternal societies, preferred provider organizations or any other entity responsible for the payment of benefits or provision for services under a group contract or individual contract on a prepayment basis.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(f) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the carrier begins to be responsible for the costs associated with treatment.

(g) "Enrollee" means an individual who is covered for the benefits offered by the carrier.

(h) "Evidence of coverage" means a statement of the essential features and services of the health care provider which is given to the subscriber by the carrier or by the group contract holder.

(i) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee or subscriber who is totally disabled on the date of termination.

(j) "Financing" means the prepayment of premium or premium equivalences for services to be received by the enrollee in the future together with acceptance and assumption of the risk, including capitation fee.

(k) "Grievance" means a written complaint submitted in accordance with the provider's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the carrier or provider to the enrolled.

(*l*) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group and may include coverage for dependents.

(m) "Group contract holder" means a person having a group contract.

(n) "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services through an organized system which combines the delivery and financing of health care to enrollees on a prepaid or other financial basis (except for enrolled responsibility for copayment or deductibles) through an organized system which combines the delivery and financing of health care. When an organization accepts and assumes risks and accepts payments, fees, premiums or premium equivalences for that risk it is deemed to be a health maintenance organization.

(o) "Health maintenance organization producer" means a person who holds a life, health and accident insurance license and a certificate of authority to represent the health maintenance organization who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

(p) "Individual contract" means a contract for health care services issued to and covering an individual may include dependents of the subscriber.

(q) "Insolvent" or "Insolvency" means that the organization has been declared insolvent and placed under an order of rehabilitation or liquidation by a court of competent jurisdiction.

(r) "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

(s) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

(t) "Participating provider" means a provider as defined in paragraph (v) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

(u) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, fraternal societies, or corporations.

(v) "Provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services.

(w) "Replacement coverage" means the benefits provided by a succeeding carrier.

(x) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

(y) "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable if the health maintenance organization is insolvent and for which no alternative arrangements have been made that are acceptable to the commissioner.

**SOURCES: Laws, 1995, ch. 613, § 2, eff from and after July 1, 1995.**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (n). The words "accepts payments, fees, premiums or premium equivalences or that risk" were changed to "accepts payments, fees, premiums or premium equivalences for that risk."The Joint Committee ratified the correction at its May 20, 1998, meeting.

**Cross References —** Health maintenance organizations to comply with §§ 83-41-401 et seq. certification requirements, see § 83-41-411.

Duty of health maintenance organization to provide opportunities for participation by providers in geographic area, see § 83-41-417.

### ATTORNEY GENERAL OPINIONS

Based on the lack of financing activities, particularly the lack of acceptance or assumption of the health care cost risk, a risk which is retained by the contracted benefits plan or insurer, an HMO is not deemed a "health maintenance organization" as defined in 83-41-303(n). Bean, December 20, 1996, A.G. Op. #96-0747.

## § 83-41-305. Requirement of certificate of authority for establishment and operation of health maintenance organization; filing, form and contents of application for certificate and attachments; qualification of foreign health maintenance organizations; effect of denial of certificate; rules and regulations.

(1) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this article. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this article. A foreign health maintenance organization may qualify under this article, subject to its registration to do business in this state as a foreign health maintenance organization under Section 79-4-15.01, Mississippi Code of 1972, and compliance with all provisions of this article and other applicable state laws.

(2) Any health maintenance organization which has not previously received a certificate of authority to operate as a health maintenance organization as of July 1, 1995, shall submit an application for a certificate of authority under subsection (3) within sixty (60) days. Each applicant may continue to operate until the commissioner acts upon the application. If an application is denied under Section 83-41-307, the applicant shall thereafter be treated as a

health maintenance organization whose certificate of authority has been revoked.

(3) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(a) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses and official positions and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day to day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

(d) A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in paragraph (c) and the health maintenance organization;

(e) A copy of the form of evidence of coverage to be issued to the enrollees;

(f) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

(g) Financial statements showing the applicant's assets, liabilities and sources of financial support. Include both a copy of the applicant's most recent (regular) certified financial statement and an unaudited current financial statement;

(h) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year, and a statement as to the sources of working capital as well as any other sources of funding;

(i) A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(j) A statement or map reasonably describing the geographic area or areas to be served;

(k) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(*l*) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(m) A description of the procedures to be implemented to meet the protection against insolvency requirements in Section 83-41-325;

(n) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements and this list must be updated at the end of each calendar quarter.

(o) Any other information as the commissioner may require to make the determinations required in Section 83-41-307.

(4)(a) The commissioner may promulgate rules and regulations as he deems necessary to the proper administration of this article to require a health maintenance organization and other entities subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (3) of this section to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both State Health Officer and commissioner at the time of the next succeeding site visit or examination.

(b) Any modification or amendment for which the commissioner's approval is required shall be deemed approved unless disapproved within thirty (30) days. The commissioner may postpone the action for a time, not exceeding an additional thirty (30) days, as necessary for proper consideration.

**SOURCES: Laws, 1995, ch. 613, § 3, eff from and after July 1, 1995.**

**Cross References** — Suspension or revocation of certificate of authority, see § 83-41-339.

## RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

## § 83-41-307. Transmission of copies of application for certificate of authority to State Health Officer; duties of State Health Officer; grant or denial of certificate of authority.

(1)(a) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall forthwith transmit copies of the application and accompanying documents to the State Health Officer.

(b) The State Health Officer shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished has complied with Section 83-41-313.

(c) Within forty-five (45) days of receipt of the application for issuance of a certificate of authority, the State Health Officer shall certify to the commissioner that the proposed health maintenance organization meets the requirements of Section 83-41-313 or notify the commissioner that the health maintenance organization does not meet the requirements and specify deficiencies.

(2) The commissioner shall within forty-five (45) days of receipt of certification or notice of deficiencies from the State Health Officer issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the commissioner being satisfied that:

(a) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(b) Any deficiencies identified by the State Health Officer have been corrected and the State Health Officer has certified to the commissioner that the health maintenance organization's proposed plan of operation meets the requirements of Section 83-41-313 and other related regulations;

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments and/or deductibles; and

(d) The health maintenance organization is in compliance with Sections 83-41-325 and 83-41-329.

(3) A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 83-41-339.

**SOURCES: Laws, 1995, ch. 613, § 4, eff from and after July 1, 1995.**

**Cross References —** Application for certificate of authority, see § 83-41-305.

Failure to meet requirements of this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

## § 83-41-309. Powers of health maintenance organization generally; notice of exercise of powers affecting financial condition of organization.

(1) The powers of a health maintenance organization include, but are not limited to, the following:

(a) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and any property as may reasonably be required for its principal office or for those purposes as may be necessary in the transaction of the business of the organization;

(b) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates loans from the health maintenance organization to a parent are prohibited without prior approval in writing from the commissioner;

(c) The furnishing of health care services through providers, provider associations or agents for providers which are under contract with or employed by the health maintenance organization;

(d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration provided all entities are qualified under this article;

(e) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(f) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(g) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

(2)(a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsection 1(a), (b) or (d) which may affect the financial condition of the health maintenance organization. The commissioner shall disapprove an exercise of power only if in his opinion it would substantially and adversely affect the financial condition of the health maintenance organization and endanger its ability to meet its obligations.

(b) The commissioner may promulgate rules and regulations exempting from the filing requirement of paragraph (a) those activities having a de minimis effect.

**SOURCES: Laws, 1995, ch. 613, § 5, eff from and after July 1, 1995.**

**Cross References —** Investments, see 83-41-323.

RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

### § 83-41-311. Bonds or insurance for directors, officers, employees, partners and contractors.

(1) Any director, officer, employee, contractor or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for the funds in a fiduciary relationship to the organization.

(2) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on employees and officers, directors and partners in an amount not less than Two Hundred Fifty Thousand Dollars ($250,000.00) for each health maintenance organization or a maximum of Five Million Dollars ($5,000,000.00) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

**SOURCES: Laws, 1995, ch. 613, § 6, eff from and after July 1, 1995.**

RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

**Am Jur.** 40 Am. Jur. 2d, Hospitals and Asylums §§ 6-13, 14-41.

**CJS.** 41 C.J.S., Hospitals §§ 11-14, 18-32, 33-44.

### § 83-41-313. Quality assurance procedures, programs and activities; maintenance and examination of patient records.

(1) The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

(2) The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(a) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan which describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for credentialing providers and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring, evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(3) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the State Health Officer.

(4) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(5) Enrollee clinical records shall be available to the State Health Officer or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the State Health Officer.

(6) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

**SOURCES: Laws, 1995, ch. 613, § 7, eff from and after July 1, 1995.**

**Cross References —** Investigation of applicants for certificate of authority by State Health Officer, see § 83-41-307.

Access to treatment records of enrollees, see § 83-41-355.

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

**Am Jur.** 40 Am. Jur. 2d, Hospitals and Asylums §§ 6, 26.

## § 83-41-315. Filing, contents and approval of group and individual contracts and evidence of coverage.

(1)(a) Every group and individual contract holder is entitled to a group or individual written contract respectively.

(b) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by the Unfair Trade Practices Act.

(c) The contract shall contain a clear statement of the following:

(i) Name and street address of the physical location of the home office of the health maintenance organization and telephone number;

(ii) Eligibility requirements;

(iii) Benefits and services within the service area;

(iv) Emergency care benefits and services;

(v) Out of area benefits and services (if any);

(vi) Copayments, deductibles or other out-of-pocket expenses;

(vii) Limitations and exclusions;

(viii) Enrollee termination;

(ix) Enrollee reinstatement (if any);

(x) Claims procedures;

(xi) Enrollee grievance procedures;

(xii) Continuation of coverage;

(xiii) Conversion;

(xiv) Extension of benefits (if any);

(xv) Coordination of benefits (if applicable);

(xvi) Subrogation (if any);

(xvii) Description of the service area;

(xviii) Entire contract provision;

(xix) Term of coverage;

(xx) Cancellation of group or individual contract holder;

(xxi) Renewal;

(xxii) Reinstatement of group or individual contract holder (if any);

(xxiii) Grace period; and

(xxiv) Conformity with state law, including but not limited to Section 83-9-1 et seq., Mississippi Code of 1972.

(2) In addition to those provisions required in subsection (1)(c), an individual contract shall provide for a ten-day (10-day) period to examine and return the contract and have the premium refunded. If services were received during the ten-day (10-day) period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for the services.

(3)(a) Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(b) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by Unfair Trade Practices Act.

(c) The evidence of coverage shall contain a clear statement of the provisions required in subsection (1)(c).

(4) The commissioner may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

(5) No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed and the proper fees paid with and approved by the commissioner, subject to subsections (6) and (7) of this section.

(6) If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval though it cannot be offered in this state without approval of the commissioner.

(7) Every form required by this section shall be filed for approval with the commissioner. At any time, after thirty (30) days' notice and for cause shown, the commissioner may withdraw approval of any form, effective at the end of the thirty (30) days. When a filing is disapproved or approval of a form is withdrawn, the commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within thirty (30) days after the commissioner has received the request for hearing.

(8) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

**SOURCES: Laws, 1995, ch. 613, § 8, eff from and after July 1, 1995.**

**Cross References —** Suspension or revocation of certificate of authority, see § 83-41-339.

## RESEARCH REFERENCES

**ALR.** Constitutional right to jury trial in cause of action under state unfair or deceptive trade practices law. 54 A.L.R.5th 631.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 15, 28.

44A Am. Jur. 2d, Insurance §§ 1828-1856.

**CJS.** 45 C.J.S., Insurance § 601.

## § 83-41-317. Filing of annual reports, financial statements, etc.

(1) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two (2) principal officers with the commissioner, with a copy to the State Health Officer, covering the preceding calendar year. Such report shall be on and in accordance to the National Association of Insurance Commissioner's Annual Statement Blanks and Instruction thereto and the NAIC Accounting Practices and Procedures Manual. The health maintenance organization shall file by the first day of March of each year, unless otherwise stated:

(a) Audited financial statements on or before June 1;

(b) A list of the providers who have executed a contract that complies with Section 83-41-325(12); and

(c)(i) A description of the grievance procedures, and

(ii) The total number of grievances handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(2) The commissioner may require such additional reports as are deemed necessary and appropriate to enable the commissioner to carry out his duties and responsibilities under this article.

**SOURCES: Laws, 1995, ch. 613, § 9, eff from and after July 1, 1995.**

**Cross References** — Documents deemed public documents, see § 83-41-353.

## § 83-41-319. Provision of information and notices to subscribers.

(1) The health maintenance organization shall provide to its subscribers a list of providers, upon enrollment, re-enrollment or at a minimum annually.

(2) Every health maintenance organization shall provide within thirty (30) days to its subscribers notice of any material change in the operation of the organization that will affect them directly.

(3) An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee, if the plan operates on a formal gatekeeper concept. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(4) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained and a number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

**SOURCES: Laws, 1995, ch. 613, § 10, eff from and after July 1, 1995.**

## § 83-41-321. Grievance procedures.

(1) Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the commissioner, after consultation with the State Health Officer, to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

(2) The commissioner or the State Health Officer may examine such grievance procedures.

**SOURCES: Laws, 1995, ch. 613, § 11, eff from and after July 1, 1995.**

**Cross References** — Suspension or revocation of certificate of authority, see § 83-41-339.

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

## § 83-41-323. Funds.

With the exception of investments made in accordance with Section 83-41-309(1)(a), the funds of a health maintenance organization shall be invested only in accordance with investment permitted by the laws of the State of Mississippi for life insurance companies (Section 83-19-51 et seq., Mississippi Code of 1972).

**SOURCES: Laws, 1995, ch. 613, § 12, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**CJS.** 41 C.J.S., Hospitals § 2.

## § 83-41-325. Minimum net worth requirement; deposits generally; computation of liabilities; contracts between health maintenance organizations and participating providers of services; insolvency plans.

(1) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of One Million Five Hundred Thousand Dollars ($1,500,000.00) and shall thereafter maintain the minimum net worth required under subsection (2).

(2) Except as provided in subsections (3) and (4) of this section, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(a) One Million Dollars ($1,000,000.00); or

(b) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first One Hundred Fifty Million Dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars ($150,000,000.00); or

(c) An amount equal to the sum of three (3) months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

(d) For a health maintenance organization in which seventy-five percent (75%) or more of the providers are paid on a capitated basis, an amount equal to the sum of:

(i) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(ii) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

(3) A health maintenance organization licensed before July 1, 1995 must maintain a minimum net worth of:

(a) Twenty-five percent (25%) of the amount required by subsection (2) by December 31, 1995;

(b) Fifty percent (50%) of the amount required by subsection (2) by December 31, 1996;

(c) Seventy-five percent (75%) of the amount required by subsection (2) by December 31, 1997;

(d) One hundred percent (100%) of the amount required by subsection (2) by December 31, 1998.

(4)(a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(c) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(5) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to him which at all times shall have a value of not less than Five Hundred Thousand Dollars ($500,000.00).

(6) A health maintenance organization that is in operation on July 1, 1995 shall make a deposit equal to Two Hundred Fifty Thousand Dollars ($250,000.00).

In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on July 1, 1995 shall be equal to Two Hundred Fifty Thousand Dollars ($250,000.00), for a total of Five Hundred Thousand Dollars ($500,000.00).

(7) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(8) All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.

(9) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

(10) The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of such health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(11) If the commissioner becomes aware of a need for additional deposits he may order a health maintenance organization to place with the State Treasurer additional deposits to meet the need to protect the securities.

(12) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims, and guaranteed renewal reserves if applicable.

The liabilities shall be computed in accordance with regulations promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(13) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that if the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(14) If the participating provider contract has not been reduced to writing as required or that the contract fails to contain the required prohibition, the

participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(15) No participating provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(16) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The commissioner in his discretion may require:

(a) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(b) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(c) Insolvency reserves;

(d) Acceptable letters of credit;

(e) Any other arrangements to assure that benefits are continued as specified above.

(17) An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the health maintenance organization at least sixty (60) days' advance notice of termination.

**SOURCES: Laws, 1995, ch. 613, § 13, eff from and after July 1, 1995.**

**Cross References** — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Applications for certificates of authority, see § 83-41-305.

Grant or denial of certificate of authority, see § 83-41-307.

Reports, see § 83-41-317.

Uncovered expenditures insolvency deposit, see § 83-41-327.

Failure to correct deficiency in minimum net worth required by this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

Rehabilitation, liquidation or supervision, see § 83-41-341.

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

## § 83-41-327. Uncovered expenditures insolvency deposits.

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place

an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(2) The deposit required under this section is in addition to the deposit required in Section 83-41-325 and is an admitted asset (as defined under insurance law) of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from such deposit or account quarterly with the approval of the commissioner.

(3) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if: (a) a substitute deposit of cash or securities of equal amount and value is made, (b) the fair market value exceeds the amount of the required deposit, or (c) the required deposit under subsection (1) is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

(4) The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining may be paid into the liquidation or receivership of the health maintenance organization.

(5) The commissioner may by regulation prescribe the time, manner and form for filing claims under subsection (4).

(6) The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports as he deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

**SOURCES: Laws, 1995, ch. 613, § 14, eff from and after July 1, 1995.**

## § 83-41-329. Proceedings upon insolvency of health maintenance organization; terms and conditions of replacement coverage.

(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for those groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. The commissioner in his sole discretion addresses reasonableness.

(3) The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes. The commissioner in his sole discretion addresses reasonableness.

(4) "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the

insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(5) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(6) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

**SOURCES: Laws, 1995, ch. 613, § 15, eff from and after July 1, 1995.**

**Cross References —** Grant or denial of certificate of authority, see § 83-41-307.
Revocation or suspension of certificate of authority, see § 83-41-339.
Proceedings upon insolvency, see § 83-41-363.

## § 83-41-331. Premium rates.

(1) No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

(2) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection (2) are met. If the commissioner disapproves the filing, he shall notify the health maintenance organization. In the notice, the commissioner shall specify the reasons for his disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing.

**SOURCES: Laws, 1995, ch. 613, § 16, eff from and after July 1, 1995.**

**Cross References** — Using schedule of charges for health care services that do not comply with requirements of this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

## § 83-41-333. Rules and regulations generally; exemptions from certification requirement.

(1) The commissioner may, after notice and hearing, promulgate rules and regulations as are necessary to provide for the licensing of health maintenance organization producers. The rules shall establish:

(a) The requirements for licensure of resident health maintenance organization producers;

(b) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(c) Any examination, prelicensing or continuing education requirements;

(d) The requirements for registering and terminating the appointment of health maintenance organization producers;

(e) Any requirements for registering any assumed names or office locations in which an health maintenance organization producer does business;

(f) The conditions for health maintenance organization producer license renewal;

(g) The grounds for denial, refusal, suspension or revocation of an health maintenance organization producer's license;

(h) Any required fees for the licensing activities of health maintenance organization producers; and

(i) Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

(2) The commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license:

(a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(b) If other existing safeguards make regulation unnecessary.

**SOURCES: Laws, 1995, ch. 613, § 17, eff from and after July 1, 1995.**

**Cross References** — Adoption of rules and regulations, see § 83-41-345.

## § 83-41-335. Operation of health maintenance organizations by insurance companies and medical service corporations.

(1) An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly

or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this article. Any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof, which health maintenance organization shall be subject to the provisions of this article.

(2) Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage if the health maintenance organization fails to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

**SOURCES: Laws, 1995, ch. 613, § 18, eff from and after July 1, 1995.**

## § 83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.

(1) The commissioner shall make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years at the expense of the health maintenance organization and provider with whom the health maintenance organization has contracted according to relevant statutes which govern examinations of insurance companies under the insurance laws of this state.

(2) The State Health Officer may make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

(3) Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner and the State Health Officer may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of providers concerning their business as per existing insurance laws, rules and regulations.

(4) The expenses of examinations under this section shall be assessed against the health maintenance organization being examined as per existing laws for examination of insurance companies or the State Health Officer for whom the examination is being conducted.

(5) In lieu of such examination, the commissioner or State Health Officer may accept the report of an examination made by the Commissioner of Insurance or State Health Officer of another state.

**SOURCES: Laws, 1995, ch. 613, § 19, eff from and after July 1, 1995.**

### § 83-41-339. Grounds and procedure for revocation, suspension or denial of certificate of authority; administrative penalty generally; correction of deficiencies in net worth; proceedings upon suspension or revocation of certificate of authority; appeals.

(1) Any certificate of authority issued under this article may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner after a hearing finds that any of the conditions listed below exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 83-41-305, unless amendments to the submissions have been filed with and approved by the commissioner;

(b) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Sections 83-41-315 and 83-41-331;

(c) The health maintenance organization does not provide or arrange for basic health care services;

(d) The State Health Officer certifies to the commissioner that:

(i) The health maintenance organization does not meet the requirements of Section 83-41-307(1)(b); or

(ii) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(e) The health maintenance organization operating in a "hazardous condition", and is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to correct, within the time prescribed by subsection (3), any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired;

(g) The health maintenance organization has failed to implement the grievance procedures required by Section 83-41-321 in a reasonable manner to resolve valid complaints;

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(j) The health maintenance organization has otherwise failed substantially to comply with this article.

(2) In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to One Thousand Dollars ($1,000.00) for each violation.

(3) The following shall pertain when insufficient net worth is maintained:

(a) Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this article is less than the minimum net worth required to be maintained by Section 83-41-325, he shall give written notice to the health maintenance organization of the amount of the deficiency and require: (i) filing with the commissioner a plan for correction of the deficiency acceptable to the commissioner and (ii) correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the commissioner. The deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in administrative supervision, rehabilitation or liquidation as per the insurance laws of this State.

(b) Unless allowed by the commissioner no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person.

However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

(4) A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

(a) Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail and to the State Health Officer. The written order shall state the grounds, charges or conduct on which suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within twenty-day (20) days from the date of mailing of the order. The said request must be filed with the commissioner within the twenty-day (20-day) period. If no written request is made, such order shall be final upon the expiration of said twenty (20) days.

(b) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the State Health Officer stating:

(i) A specific time for the hearing, which may not be less than twenty (20) days after mailing of the notice of hearing; and

(ii) A specific place for the hearing which shall be at the discretion of the commissioner and which may be either in Jackson, Hinds County, Mississippi or in the county where the health maintenance organization's or applicant's principal place of business is located.

(iii) If a hearing is requested, the State Health Officer or his designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the State Health Officer with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner.

After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the commissioner shall take whatever action he deems necessary based on written findings and shall mail his decision to the health maintenance organization or applicant with a copy to the State Health Officer. The action of the commissioner and the recommendation and findings of the State Health Officer shall be subject to review under the Administrative Rules of Practice and Procedure Act.

(5) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(6) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization under supervision of the commissioner. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

(7) Any appeal from a decision of the commissioner under this section shall be to the Chancery Court of the First Judicial District of Hinds County, Mississippi within thirty days (30) from the final Order of the commissioner.

**SOURCES: Laws, 1995, ch. 613, § 20, eff from and after July 1, 1995.**

**Cross References** — Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

Administrative penalties in lieu of suspension or revocation of certificate of authority, see § 83-41-349.

## § 83-41-341. Rehabilitation, liquidation or administrative supervision of health maintenance organizations.

(1) Any rehabilitation, liquidation or administrative supervision of a health maintenance organization shall be deemed to be the same as the rehabilitation, liquidation or administrative supervision of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, and administrative supervision of insurance companies. The commissioner may apply for an order directing him to rehabilitate or liquidate a health maintenance organization upon any one or more grounds set out in Section 83-41-325 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by the Rehabilitation and Liquidation Act (Section 83-24-1 et seq., Mississippi Code of 1972) for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

(3) Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in Section 83-24-1 et seq., Mississippi Code of 1972.

**SOURCES: Laws, 1995, ch. 613, § 21, eff from and after July 1, 1995.**

## § 83-41-343. Remedies for correction of financial conditions of health maintenance organizations deemed hazardous to enrollees, creditors, or general public and violations of article.

(1) Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this article, he may, after notice and hearing,

order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(a) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(b) Reduce the volume of new business being accepted;

(c) Reduce expenses by specified methods;

(d) Suspend or limit the writing of new business for a period of time;

(e) Increase the health maintenance organization's capital and surplus by contribution; or

(f) Take such other steps as the commissioner may deem appropriate under the circumstances.

(2) For purposes of this section, the violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of this article.

(3) The commissioner is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in subsection (1) of this section.

(4) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of the insurance laws of the State of Mississippi.

**SOURCES: Laws, 1995, ch. 613, § 22, eff from and after July 1, 1995.**

## § 83-41-345. Adoption of rules and regulations.

The commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this article.

**SOURCES: Laws, 1995, ch. 613, § 23, eff from and after July 1, 1995.**

## § 83-41-347. Fees.

(1) Every health maintenance organization subject to this article shall pay to the commissioner the following fees:

| | |
|---|---|
| (a) For filing an application for a certificate of authority for a health maintenance organization and amendment thereto | $5,000.00; |
| (b) For filing an amendment to the organization documents that requires approval | $ 50.00; |
| (c) For filing an amendment "for information only" | $ 25.00; |
| (d) For filing each annual report | $ 500.00; |
| (e) Annual renewal of Certificate of Authority | $ 500.00; |

(f) Policy forms, certificates, endorsements, riders, applications and rates ........................................................$ 15.00;

(2) The State Health Officer may utilize state employees or he may contract with other persons, companies, corporations and entities to carry out the duties and responsibilities under this article. If it is necessary to contract for the performance of the duties and responsibilities required under this article, the expense for the services shall be charged to the carrier and paid directly to the contracting party. The charge shall be approved by the State Health Officer prior to the services being rendered when sufficient information is available to the State Health Officer, though the carrier is responsible for all charges expended when additional services are necessary to carry out the duties and responsibilities for finalization of the licensing process. The method and procedure for the payment of the expenses may be addressed in the regulations promulgated under this article.

**SOURCES: Laws, 1995, ch. 613, § 24, eff from and after July 1, 1995.**

**Cross References —** Administrative penalties in lieu of suspension or revocation of certificate of authority, see § 83-41-349.

## § 83-41-349. Imposition of administrative penalties; informal proceedings for investigation and correction or prevention of violations; cease and desist orders.

(1) The commissioner may, in lieu of suspension or revocation of a certificate of authority under Section 83-41-339, levy an administrative penalty in an amount not less than One Hundred Dollars ($100.00) per violation, nor more than One Thousand Dollars ($1,000.00) per violation, if reasonable; notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2)(a) If the commissioner or the State Health Officer shall for any reason have cause to believe that any violation of this article has occurred or is threatened, the commissioner or State Health Officer may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a hearing with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the State Health Officer may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this article are satisfied.

(3)(a) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this article.

(b) Within ten (10) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearings shall be conducted pursuant to rules of practice and procedure before the Mississippi Insurance Department and judicial review shall be available as provided by Section 83-41-339.

(4) In the case of any violation of the provisions of this article, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Chancery Court of the First Judicial District of Hinds County, Jackson, Mississippi.

(5) Notwithstanding any other provisions of this article, if a health maintenance organization fails to comply with the net worth requirement of this article, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

**SOURCES: Laws, 1995, ch. 613, § 25, eff from and after July 1, 1995.**

## § 83-41-351. Solicitation of enrollees.

(1) This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this article.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

**SOURCES: Laws, 1995, ch. 613, § 26, eff from and after July 1, 1995.**

## § 83-41-353. Documents deemed public documents.

All applications, filings and reports required under this article shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 83-41-317.

**SOURCES: Laws, 1995, ch. 613, § 27, eff from and after July 1, 1995.**

## § 83-41-355. Confidentiality of data or information; claims of privilege; civil liability of members of health review committees; discovery of information considered by and records of health review committees; access to treatment records, etc., of enrollees.

(1) Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this article; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished information to the health maintenance organization is entitled to claim.

(2) A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to a committee shall not be subject to liability for civil damages or any legal action in consequence of the action, nor shall the health maintenance organization which established a committee or the officers, directors, employees or agents of the health maintenance organization be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(3)(a) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting a committee, or any person assisting or furnishing information to a committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

(b) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (3)(a) by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

(4) To fulfill its obligations under Section 83-41-313, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

**SOURCES: Laws, 1995, ch. 613, § 28, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

Waiver of evidentiary privilege by inadvertent disclosure—state law. 51 A.L.R.5th 603.

## § 83-41-357. Contracting authority of State Health Officer.

The State Health Officer in carrying out his obligations under this article, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. The recommendations may be accepted in full or in part by the State Health Officer.

**SOURCES: Laws, 1995, ch. 613, § 29, eff from and after July 1, 1995.**

## § 83-41-359. Acquisitions, mergers and consolidations of health maintenance organizations.

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization, information required by the commissioner substantially similar to the information required pursuant to Section 83-6-1 et seq., Mississippi Code of 1972, and the offer, request, invitation, agreement or acquisition has been approved by the commissioner.

**SOURCES: Laws, 1995, ch. 613, § 30, eff from and after July 1, 1995.**

## § 83-41-361. Adoption of coordination of benefits provisions.

(1) Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health care plans.

(2) To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are covered under the terms of their group contracts or evidence of coverage.

**SOURCES: Laws, 1995, ch. 613, § 31, eff from and after July 1, 1995.**

## § 83-41-363. Proceedings upon insolvency of health maintenance organization.

(1) When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the commissioner may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 83-41-329. The commissioner may not assess in any one (1) calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state the prior calendar year.

(2)(a) The commissioner may use funds obtained under subsection (1) to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under Section 83-41-329, and administrative costs. The commissioner may by regulation prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

(b) The Commissioner may not use funds obtained under subsection (1) to pay claims by participating providers for services rendered to subscribers or enrollees prior to insolvency of the health maintenance organization.

(3)(a) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(b) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the commissioner to the extent of the benefits received. The commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon such person. The commissioner is subrogated to these rights against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(c) The assignment or subrogation rights of the commissioner and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(4) When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the commissioner will distribute on a pro rata basis any amounts received under subsection (1) which are not de minimis to the health maintenance organizations which have been assessed under this section.

(5) The aggregate coverage of uncovered expenditures under this section shall not exceed Three Hundred Thousand Dollars ($300,000.00) with respect to any one (1) individual. Continuation of coverage shall not continue for more than the lesser of one (1) year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The commissioner may provide continuation of coverage on any reasonable basis; including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the commissioner.

(6) The commissioner may waive an assessment of any health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within thirty (30) days after notice is subject to a civil forfeiture of not more than One Thousand Dollars ($1,000.00) per day or suspension or revocation of its certificate of authority or both fine and suspension. Any action taken by the commissioner in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with the Chancery Court of the First Judicial District of Hinds County, Mississippi.

**SOURCES: Laws, 1995, ch. 613, § 32, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 15, 28.

**CJS.** 44 C.J.S., Insurance §§ 189 et seq.

## § 83-41-365. Contracting authority of commissioner.

The commissioner may contract with the necessary personnel to carry out the duties and responsibilities created by this article and make assessments for the expenses incurred in carrying out the duties and responsibilities of this article.

**SOURCES: Laws, 1995, ch. 613, § 33, eff from and after July 1, 1995.**

### RESEARCH REFERENCES

**Am Jur.** 40 Am. Jur. 2d, Hospitals and Asylums § 5.

## Article 9.

## Patient Protection Act of 1995.

Sec.
83-41-401. Short title.
83-41-403. Definitions.
83-41-405. Requirement of certification of managed care plans offered or provided to persons residing in Mississippi; termination of plans.
83-41-407. Fees.
83-41-409. Conditions for certification or recertification.
83-41-411. Compliance with article by health maintenance organizations.
83-41-413. Regulations.
83-41-415. Applicability of Articles 7 and 9 to Division of Medicaid in Office of Governor.
83-41-417. Geographic areas served; opportunity to apply for participation.

### § 83-41-401. Short title.

This article shall be known and may be cited as the "Patient Protection Act of 1995."

**SOURCES: Laws, 1995, ch. 613, § 36, eff from and after July 1, 1995.**

### § 83-41-403. Definitions.

As used in this article:

(a) "Department" means the Mississippi Department of Insurance.

(b) "Managed care plan" means a plan operated by a managed care entity as described in subparagraph (c) that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(i) Arrangements with selected providers to furnish health care services;

(ii) Explicit standards for the selection of participating providers;

(iii) Organizational arrangements for ongoing quality assurance, utilization review programs and dispute resolution; and

(iv) Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

(c) "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as described in subparagraph (d) that operates a managed care plan.

(d) "Managed care contractor" means a person or corporation that:

(i) Establishes, operates or maintains a network of participating providers;

(ii) Conducts or arranges for utilization review activities; and

(iii) Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(e) "Participating provider" means a physician, hospital, pharmacy, pharmacist, dentist, nurse, chiropractor, optometrist, or other provider of health care services licensed or certified by the state, that has entered into an agreement with a managed care entity to provide services, products or supplies to a patient enrolled in a managed care plan.

**SOURCES: Laws, 1995, ch. 613, § 37, eff from and after July 1, 1995.**

**Cross References —** Powers of regional commissions created for the purpose of establishing mental illness and mental retardation facilities and services, see § 41-19-31.

Duty of managed care entity to provide opportunities for participation by health care providers in geographic area, see § 83-41-417.

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

## § 83-41-405. Requirement of certification of managed care plans offered or provided to persons residing in Mississippi; termination of plans.

The department shall establish a process for the certification of managed care plans offered or provided to persons residing in Mississippi. No such plan shall be offered or provided to persons residing in this state unless it has been certified by the department. Any managed care plan certified by the department must be recertified annually, and the department shall establish procedures to ensure the continued compliance with the requirements of Section 83-41-409 through the recertification process. The department shall terminate the certificate of any managed care plan if such plan no longer meets the applicable requirements for certification. The department shall provide any such plan with an opportunity for a hearing on the proposed termination.

**SOURCES: Laws, 1995, ch. 613, § 38, eff from and after July 1, 1995.**

## § 83-41-407. Fees.

The department shall establish a fee to cover the costs of issuing and renewing the certifications authorized by this article and the fees shall be used solely for the administration of this article.

**SOURCES: Laws, 1995, ch. 613, § 39, eff from and after July 1, 1995.**

## § 83-41-409. Conditions for certification or recertification.

In order to be certified and recertified under this article, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; and

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed.

**SOURCES: Laws, 1995, ch. 613, § 40, eff from and after July 1, 1995.**

## § 83-41-411. Compliance with article by health maintenance organizations.

Health maintenance organizations must comply with the certification requirements in this article in addition to such other laws as might relate thereto.

**SOURCES: Laws, 1995, ch. 613, § 41, eff from and after July 1, 1995.**

**Cross References** — Health maintenance organizations generally, see §§ 83-41-301 et seq.

## § 83-41-413. Regulations.

The department shall adopt regulations to implement the provisions of this article and may obtain any information from managed care plans that is necessary to determine if such plan should be certified or recertified.

**SOURCES: Laws, 1995, ch. 613, § 42, eff from and after July 1, 1995.**

## § 83-41-415. Applicability of Articles 7 and 9 to Division of Medicaid in Office of Governor.

Articles 7 and 9 do not apply to the Division of Medicaid in the Office of the Governor.

**SOURCES: Laws, 1995, ch. 613, § 43, eff from and after July 1, 1995.**

**Cross References** — Articles 7 and 9 of this chapter, see §§ 83-41, 301 et seq. and 83-41-401 et seq.

## § 83-41-417. Geographic areas served; opportunity to apply for participation.

A health maintenance organization as defined in Section 83-41-303, and a managed care entity as defined in Section 83-41-403, shall establish procedures to give interested health care providers located in the geographic area served an opportunity to apply for participation.

**SOURCES: Laws, 1995, ch. 613, § 44, eff from and after July 1, 1995.**

# CHAPTER 43

## Nonprofit Dental Service Corporations

Sec.

83-43-1. Citation.
83-43-3. Definitions.
83-43-5. Unauthorized nonprofit dental service forbidden.
83-43-7. Regulation and supervision.
83-43-9. License.
83-43-11. Scope of service.
83-43-13. Rights of dentists.
83-43-15. Corporate rights and powers.
83-43-17. Limitation of subscriber's contract.
83-43-19. Officers may subscribe for service.
83-43-21. Financial report.
83-43-23. Investment.
83-43-25. Dental service report.
83-43-27. Agent's performance of functions.
83-43-29. Penalties.
83-43-31. Enforcement.
83-43-33. Partial tax exemption.
83-43-35. Dissolution or liquidation.
83-43-37. Construction.

## § 83-43-1. Citation.

This chapter shall be known and may be cited as the "Nonprofit Dental Service Corporation Law".

**SOURCES: Codes, 1942, § 8775-01; Laws, 1962, ch. 234, § 1, eff from and after passage (approved May 7, 1962).**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 15, 66.

## § 83-43-3. Definitions.

As used in this chapter:

(a) "Dentists" means persons holding a license to practice dentistry under Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(b) "Dental services" include the general and usual services rendered and care administered by dentists as defined in Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(c) "Nonprofit dental service corporation" includes a corporation organized and operated under the provisions of Section 79-11-101, Mississippi Code of 1972, and all other applicable statutes governing nonprofit corporations.

(d) "State Board of Health" means Mississippi State Board of Health.

(e) "Court" means the chancery court of the county where the principal office of the nonprofit dental corporation is or is to be located.

**SOURCES: Codes, 1942, § 8775-02; Laws, 1962, ch. 234, § 2; Laws, 1997, ch. 410, § 22, eff from and after July 1, 1997.**

## § 83-43-5. Unauthorized nonprofit dental service forbidden.

It shall be unlawful for any person, copartnership, association, common law trust, or corporation, except when especially organized and authorized under the provisions of the nonprofit corporation statutes for the purpose, to establish, maintain, or operate a nonprofit dental service plan whereby dental services may be provided to persons or groups of persons for prepayment, periodical, or lump sum payments, but this shall not be construed as preventing a person, copartnership, association, common law trust, or corporation from furnishing dental services among its or his employees when the employee is not charged for such service. Nor shall any provision in this chapter be construed to apply to beneficial, benevolent, fraternal, benefit societies having a lodge system and representative form of government.

**SOURCES: Codes, 1942, § 8775-03; Laws, 1962, ch. 234, § 3; Laws, 1997, ch. 307, § 6, eff from and after July 1, 1997.**

**Cross References —** Fraternal benefit societies, see §§ 83-29-1 et seq.

## § 83-43-7. Regulation and supervision.

A nonprofit dental service corporation shall be subject to regulation and supervision by the state board of health, state auditor, and the attorney general as provided by this chapter. It shall not be subject to the laws of this state now in force, except as herein specifically stated, relating to insurance and corporations engaged in the business of insurance, nor to any law hereafter enacted relating to insurance and corporations engaged in the business of insurance, unless such law specifically and in exact terms applies to such nonprofit dental service corporation.

**SOURCES: Codes, 1942, § 8775-04; Laws, 1962, ch. 234, § 4, eff from and after passage (approved May 7, 1962).**

**Editor's Note —** Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor", and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as

§ 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration".

**Cross References —** Qualifications of state fiscal management board, see Miss Const § 134.

Qualifications of attorney general, see § 7-5-1.

Qualifications of dentist member of state board of health, see § 41-3-1.

Regulation and supervision of insurance corporations, see §§ 83-1-1 et seq.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 67.

## § 83-43-9. License.

A nonprofit dental service corporation may not enter into dental service contracts under the provisions hereof until it has procured a formal certificate or license from the state board of health authorizing it to do so. Application for such certificate of authority or license shall be made on such forms as the state board of health may prescribe and shall be accompanied by the following documents: (a) certified copy of charter of incorporation, (b) certified copy of current bylaws, (c) an affidavit of the secretary of the Mississippi State Board of Dental Examiners setting forth that he has satisfactory evidence that at least twenty percent (20%) of the licensed dentists residing and actively practicing in the state have agreed to render professional service to subscribers under such plan, (d) a certificate from the Mississippi State Board of Dental Examiners approving the licensing of such dental service corporation, and (e) such other information as the state board of health may require concerning the public interest, welfare, and necessity of licensing such dental service corporation. The state board of health shall issue a certificate of authority or license upon payment of a fee of Twenty-five Dollars ($25.00) and upon being satisfied that the public interest, welfare, and necessity will be served by so doing. All licenses issued to every such corporation shall expire on the last day of the next succeeding March, but shall be subject to annual renewal under the foregoing terms and conditions.

**SOURCES: Codes, 1942, § 8775-05; Laws, 1962, ch. 234, § 5, eff from and after passage (approved May 7, 1962).**

**Cross References —** General duties of state board of health, see § 41-3-15.

Powers and duties of state board of dental examiners, see § 73-9-13.

## § 83-43-11. Scope of service.

(1) A nonprofit dental service corporation may, by its articles of incorporation, its bylaws, or resolutions of its board of directors, limit the dental services that it will provide for its subscribers and may divide such dental services as it elects to provide into classes or kinds; and it may enter into contracts with its subscribers or groups of subscribers to secure dental services of any kind or class so named and delimited.

(2) A nonprofit dental service corporation shall not provide dental services for its subscribers otherwise than through licensed dentists.

(3) A nonprofit dental service corporation shall provide dental services only to persons domiciled within the state; but if a subscriber regularly domiciled within the state and entitled to dental services, or any of his dependents so entitled, necessarily employs dental services within the meaning of this chapter while absent from the state, a dental service corporation to which he is a subscriber may, in its discretion and if satisfied as to the necessity for such services and satisfied that it was such as the subscriber would have been entitled to under similar circumstances in this state, pay to the dentist or dentists who rendered the services such fees and charges as would have been payable if the services had been rendered in this state. A nonprofit dental service corporation organized under the laws of this state and operating near its boundaries may, with the consent of the proper officers of and as authorized by the law of the adjacent state, provide dental services therein, but all operations of any such corporation, whether within or without this state, shall remain at all times subject to the provisions of this chapter.

(4) All dental services provided by or on behalf of a nonprofit dental service corporation shall be in accordance with the best dental practice in the community at the time, but the corporation providing such services shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any officer or employee or on the part of any dentist in the course of rendering dental services to subscribers; and the corporation may so provide in its contracts with subscribers.

**SOURCES: Codes, 1942, § 8775-05; Laws, 1962, ch. 234, § 5, eff from and after passage (approved May 7, 1962).**

**Cross References —** Enforcement of Dental Practice Law, see § 73-9-17.

### RESEARCH REFERENCES

**ALR.** Liability for dental malpractice in provision or fitting of dentures. 77 A.L.R.4th 222.

## § 83-43-13. Rights of dentists.

(1) Every dentist practicing within the area covered by any nonprofit dental service corporation shall have the right, on complying with such regulations as the corporation may make and with the approval of the state board of health, to register with such corporation for general or special dental service, as the case may be, within that area. Any nonprofit dental service corporation may, with the approval of the state board of health and the state board of dental examiners, remove from its register the name of any dentist, after due notice and hearing, for cause satisfactory to the corporation.

(2) A nonprofit dental service corporation shall impose no restrictions on the dentists who administer to its subscribers as to methods of diagnosis or

treatment. The relation between a subscriber or any of his dependents and the dentist shall be identical with the relation that ordinarily exists in the community between such doctor and his patient. No person shall be permitted to interfere with a patient's choice or selection of his dentist after that choice or selection has been made by an adult of sound mind; and any dentist shall have freedom of choice in registering for services with the corporation and may refuse to accept individual cases, so long as such refusal does not have the effect of an abrogation or revocation of any agreement existing between him and the corporation prior to its expiration.

(3) All matters, disputes, or controversies relating to the dental services rendered by the dentists or any questions involving professional ethics shall be considered, acted upon, disposed of, and determined by dentists, as selected in a manner prescribed in the bylaws of the nonprofit dental service corporations.

**SOURCES: Codes, 1942, § 8775-06; Laws, 1962, ch. 234, § 6, eff from and after passage (approved May 7, 1962).**

**Cross References** — Duty of state board of health to supervise health interests of people, see § 41-3-15.

## § 83-43-15. Corporate rights and powers.

In addition to the rights and powers that may be exercised by nonprofit corporations under Sections 79-11-1 through 79-11-33, Mississippi Code of 1972, nonprofit dental service corporations created and organized under the provisions of this chapter shall be authorized to exercise the following rights and powers, to wit:

(a) To encourage, foster, and finance professional and scientific study and research in the general field of dentistry; to make studies and conduct investigations designed to develop information, statistics, and knowledge pertaining to all aspects of dental service payment plans, and to assist in the education and enlightenment of the public concerning the needs and advantages of adequate dental treatment and care.

(b) To enter into and carry out contracts for furnishing dental services to individuals and groups of individuals, provided, however, that no contract by or on behalf of any nonprofit dental service corporation shall provide for the payment of any cash or other material benefit by that corporation to a subscriber on account of illness or injury nor be in any way related to the payment of any such benefit by any other agency.

(c) To procure and enter into contracts with dentists, hygienists, laboratory technicians, oral surgeons, hospitals, pharmacies, and other persons, firms, and corporations to carry out any of the objects and purposes of this corporation.

(d) To operate an administrative office and dental clinics, laboratories, and other facilities appropriate or convenient for the rendition of dental services, and to employ personnel for the conduct thereof.

(e) To establish and maintain funds secured through payments to be used to defray the cost of dental services, to predicate payments into such funds on actuarial prediction and experience, and to issue contracts entitling the holder or subscriber thereto to dental services as enumerated therein and subject to the terms and provisions as may be therein provided.

(f) To establish eligibility requirements for individuals and groups of individuals seeking to subscribe to its dental service plans, and to determine the eligibility thereunder of persons subscribing to its contracts. Any and all requisites thus fixed and all contracts for dental services offered by the corporation shall be subject to the approval of the state board of health.

(g) To accept gifts, donations, contributions and property by bequest or devise, or in trust, and to use and apply the same in furtherance of the objects and purposes of such corporation.

**SOURCES: Codes, 1942, § 8775-07; Laws, 1962, ch. 234, § 7, eff from and after passage (approved May 7, 1962).**

**Editor's Note** — Sections 79-11-1 through 79-11-29, referred to in the opening paragraph of this section, were repealed by Laws of 1987, ch. 485, § 153, effective January 1, 1988. For text of the Mississippi Nonprofit Corporation Act, see §§ 79-11-101 et seq.

**Cross References** — General duties of state board of health, see § 41-3-15.

## § 83-43-17. Limitation of subscriber's contract.

A nonprofit dental service corporation may, as a condition precedent to entering into a contract with an applicant or group of applicants for dental service:

(a) Require a physical examination of the applicant and of each of his dependents, if any, and proof of his or their substantial freedom from any disease or condition requiring immediate dental service or likely to require it within the next six (6) months before a contract becomes effective, or

(b) require a waiting period after a contract is entered into and before the subscriber is entitled to dental service, or

(c) require that the subscriber or someone on his behalf shall pay the stated fee or fees for dental services in the care of any given illness or injury or other condition requiring dental service before becoming entitled to treatment under the terms of the contract.

(d) Provided, however, that nothing in this chapter shall be construed to require any individual, or group of individuals, to become a subscriber or subscribers to any such plan against his or their own free will and accord.

**SOURCES: Codes, 1942, § 8775-08; Laws, 1962, ch. 234, § 8, eff from and after passage (approved May 7, 1962).**

## § 83-43-19. Officers may subscribe for service.

Every department, commission, officer, or other agency of the state, or of any political subdivision thereof, who is authorized or charged by law with the duty of providing dental services within the meaning of this chapter for persons unable to provide it entirely at their own expense, or to procure it through persons to whose support and assistance they are by law entitled, is hereby empowered in the exercise of his authority to provide such service if, in his judgment, it is in the public interest so to do, through a subscription or subscriptions paid for from any lawfully available public funds with any nonprofit dental service corporation on behalf of any person or persons entitled to such relief. Provided, however, that the extent of public funds contributed to such services, other than those funds disbursed by the state welfare program, shall not exceed the limitations authorized by Section 25-15-103, Mississippi Code of 1972.

**SOURCES: Codes, 1942, § 8775-09; Laws, 1962, ch. 234, § 9, eff from and after passage (approved May 7, 1962).**

**Cross References** — Group insurance for public employees, see §§ 25-15-101 et seq.

## § 83-43-21. Financial report.

Every nonprofit dental service corporation shall, on or before the first day of March of every year, file with the state auditor of public accounts a statement verified by at least two (2) of the principal officers of the corporation, summarizing its financial activities during the calendar year immediately preceding and showing its financial condition at the close of business on the thirty-first day of December of that year. Such statement shall be in such form and shall contain such matter as the state auditor prescribes. The financial affairs and status of every such corporation may be examined by the attorney general of the state not less frequently than once in every three (3) years and, for that purpose, the attorney general and his assistants shall be entitled to the aid and cooperation of the officers and employees of the corporation and shall have convenient access to all books, records, papers, and documents that relate to the business of the corporation. They shall have authority to examine the officers, agents, employees, and subscribers for the dental services of the corporation, all cooperating dentists registered with the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to its affairs, transactions, and financial condition. Such examinations shall be made at such times and with such frequency as the attorney general may determine. He or the state auditor may, at any time without making such examination, call on any such corporation for a written report, authenticated by at least two (2) of its principal officers, concerning the financial affairs and status of the corporation.

**SOURCES: Codes, 1942, § 8775-10; Laws, 1962, ch. 234, § 10, eff from and after passage (approved May 7, 1962).**

**Editor's Note** — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor", and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration".

**Cross References** — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

## § 83-43-23. Investment.

Surplus funds, if any, of any such corporation may be invested and, if invested, shall be in compliance with the requirements of law for the investment of the surplus of life insurance companies.

**SOURCES: Codes, 1942, § 8775-11; Laws, 1962, ch. 234, § 11, eff from and after passage (approved May 7, 1962).**

**Cross References** — Authorized investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

## § 83-43-25. Dental service report.

Every nonprofit dental service corporation shall, on or before the first day of March of every year, file with the state board of health a report of its activities other than its financial activities during the calendar year immediately preceding. Every such report shall be authenticated by at least two (2) of the principal officers of the corporation and shall be in such form and contain such matter as the state board of health prescribes. The state board of health is hereby authorized to inquire into the activities of the nonprofit dental service corporations and to determine whether the corporation is providing adequate dental services to its subscribers in accordance with the best dental practice in the community. The secretary of the state board of health and his agents shall be entitled to the aid and cooperation of the officers and employees of the corporation and shall have convenient access to all books, records, papers, and documents that relate to the business of the corporation. They shall have authority to examine the officers, agents, employees and subscribers for the service of the corporation, all dentists registered with the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to the affairs, transactions, and conditions of the corporation other than financial. Examinations may be made at such times and with such frequency as the secretary of the state board of health may determine. The secretary of the state board of health may, at any time without making any such examination, call on any such corporation for a written report, authenticated by at least two (2) of its principal officers, concerning the affairs of the corporation other than its financial affairs. In the event the secretary of the state board of health finds that the nonprofit dental service corporation does not provide adequate dental services to its subscribers in accordance with the best dental practice in the community, the said secretary may notify the corporation of his findings and order the corporation, in specific terms, to extend or improve the dental services furnished by the corporation. Within thirty (30) days after receipt of such notice from the secretary, the corporation may petition the court to show cause why the action of the secretary of the state board of health should not be set aside or modified. The court is given jurisdiction and authority to entertain and determine any such proceeding and controversy.

**SOURCES: Codes, 1942, § 8775-12; Laws, 1962, ch. 234, § 12, eff from and after passage (approved May 7, 1962).**

**Cross References** — Composition and duties of state board of health, see §§ 41-3-1 et seq.

## § 83-43-27. Agent's performance of functions.

Any nonprofit dental service corporation may select any person, copartnership, association, common law trust, or corporation to act as its agent in the performance of any of its functions. Any such delegation of authority shall not operate to release the nonprofit dental service corporation from any of its duties and responsibilities required by this chapter.

**SOURCES: Codes, 1942, § 8775-13; Laws, 1962, ch. 234, § 13, eff from and after passage (approved May 7, 1962).**

## § 83-43-29. Penalties.

Any dentist and any other person, copartnership, association, common law trust, or corporation who violates any provision of this chapter or of any order of the state board of health, of the attorney general, or of the state auditor made pursuant thereto, or that either prevents the state board of health or the state officers to discharge any duties imposed upon them by this chapter, or fraudulently procures or attempts to procure any benefits under this chapter, or that willfully makes any false statement in any proceeding or report under the provisions of this chapter, shall be guilty of a misdemeanor and, on conviction thereof, shall be sentenced to pay a fine of not more than Five Hundred Dollars ($500.00), or to be imprisoned for not more than six (6) months, or both such fine and imprisonment. Any act or default by any corporation, association, or common law trust in violation of any provisions of the chapter, or of any order of the department made pursuant thereto shall be deemed to be the act or default of its officers or directors who participated in authorizing or effecting such act or default, or who knowingly permitted it.

**SOURCES: Codes, 1942, § 8775-14; Laws, 1962, ch. 234, § 14, eff from and after passage (approved May 7, 1962).**

**Editor's Note** — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor", and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration".

**Cross References —** Authority of state officers and state board of health to regulate and supervise nonprofit dental service corporations, see § 83-43-7.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

## § 83-43-31. Enforcement.

When necessary to effect the purposes of this chapter, in addition to all other remedies in law or equity, the attorney general or state auditor, the secretary of the state board of health, or either of them, may be and are hereby authorized to petition the court for a mandamus or injunction to prevent any violation of the provisions of this chapter, or the continuance of any such violation, or to enforce compliance herewith. The court is hereby vested with authority to entertain jurisdiction on any such petition to determine the cause and to issue such process as may be necessary to accomplish the purposes of this chapter.

**SOURCES: Codes, 1942, § 8775-15; Laws, 1962, ch. 234, § 15, eff from and after passage (approved May 7, 1962).**

**Editor's Note —** Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor", and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration".

**Cross References —** Authority of state officers and state board of health to enforce compliance with nonprofit dental service corporation law, see § 83-43-7.

## § 83-43-33. Partial tax exemption.

Every corporation organized pursuant to, or subject to, the provisions of this chapter is hereby declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation, except, however, that such corporation shall not be exempt from ad valorem taxes upon real estate and motor vehicles owned by it.

**SOURCES: Codes, 1942, § 8775-16; Laws, 1962, ch. 234, § 16; Laws, 1978, ch. 441, § 9, eff from and after July 1, 1978.**

**Cross References** — Exemption from taxation of property of charitable and benevolent institutions, see §§ 27-31-1 et seq.

## § 83-43-35. Dissolution or liquidation.

Any dissolution or liquidation of a corporation subject to the provisions of this chapter shall be conducted under the supervision of the attorney general and the state board of health. All assets of the corporation shall, upon dissolution or liquidation and after adequate provision is made for the discharge of all debts and obligations of the corporation, be transferred and distributed to the state board of health to be expended by it in providing dental care and treatment for indigent persons.

**SOURCES: Codes, 1942, § 8775-17; Laws, 1962, ch. 234, § 17, eff from and after passage (approved May 7, 1962).**

## § 83-43-37. Construction.

It is hereby declared to be the purpose and intent of this chapter and the policy of the legislature to authorize qualified dentists engaged in private practice to provide adequate dental services for residents of this state through a sound prepayment plan with the cooperation of the Mississippi Dental Association and state board of dental examiners, with appropriate state supervision to insure that subscribers thereto will continue to receive the highest type professional dental care with their free and voluntary choice of dentists, and at the same time it is the purpose and intent of this chapter and the policy of the legislature to maintain the standing and promote the progress of the science and art of dental surgery in this state. The courts of this state are hereby directed to construe this chapter liberally in order to accomplish those ends.

**SOURCES: Codes, 1942, § 8775-18; Laws, 1962, ch. 234, § 18, eff from and after passage (approved May 7, 1962).**

## CHAPTER 45

## Nonprofit, Community Service Blood Supply Plans

Sec.
83-45-1. Operation of plan as constituting the writing of insurance.
83-45-3. Requirement for licensing.
83-45-5. Approval of articles; issuance of license.
83-45-7. Examinations; annual reports.
83-45-9. Solicitation of membership.
83-45-11. Approval of general administrative expenses.
83-45-13. Dissolution.

### § 83-45-1. Operation of plan as constituting the writing of insurance.

The operation of a blood supply plan, on a nonprofit, community service basis, for the purpose of promoting and encouraging the donation of human blood for medicinal and transfusion uses may or may not constitute the writing of insurance. However, an agreement between such a nonprofit organization promoting and encouraging such blood donation and one or more of its donors by which the nonprofit organization agrees to pay the cost, or a part thereof, of supplying transfusion blood to such donor or designated members of his family shall constitute a contract of insurance.

This form of insurance will be governed only by this chapter.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

### § 83-45-3. Requirement for licensing.

Requirement for licensing shall be as follows:

(a) A deposit with any depository approved by the state for the benefit of policyholders/members in the amount of One Dollar ($1.00) for each policyholder currently insured to guarantee perpetuation of the organization until all membership contracts are terminated.

(b) A deposit in a like amount to a catastrophe fund, but this deposit shall be made on the first renewal of each contract.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

### § 83-45-5. Approval of articles; issuance of license.

Such company or organization shall have its articles of incorporation or articles of organization approved by the attorney general and the commissioner of insurance and subsequently filed in the office of secretary of state. Filing fee for such articles shall be Five Dollars ($5.00). A license shall be issued by the commissioner of insurance to expire the next ensuing December

31, and the fee for such license for one (1) year shall be Ten Dollars ($10.00) per year or any part thereof.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

## § 83-45-7. Examinations; annual reports.

Any such organization shall be exempt from regular examination by the insurance department, but shall be examined when deemed advisable by the commissioner of insurance.

Annual reports shall be filed with the insurance department in the manner and form prescribed by the commissioner of insurance.

Upon submission of annual statements, same shall be reviewed by the commissioner of insurance and the commissioner may issue such orders as necessary to stabilize operation of the company or organization.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

## § 83-45-9. Solicitation of membership.

Solicitation of membership may be made through direct advertising, group solicitation, by officers or by individuals without licensing of solicitors, provided this is the only insurance which is offered or solicited by the company or organization.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

## § 83-45-11. Approval of general administrative expenses.

General administrative expenses shall be submitted to and approved by the department of insurance.

**SOURCES: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).**

## § 83-45-13. Dissolution.

Upon dissolution of such organization, the department of insurance shall be satisfied that all policyholders/members' claims have been paid before approving the release of deposits.

In event of dissolution and surrender of articles of association and/or charter, any surplus after reimbursement of organizational funds and any other contribution to surplus shall be prorated among such organizing contributors at the highest rate of interest possible, not to exceed ten percent (10%). When and if surplus exists in excess of reimbursements hereinabove set out, such amount shall escheat to the general fund of the State of Mississippi upon dissolution of the company or organization.

**SOURCES:** Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

# CHAPTER 47

## Nonprofit Medical Liability Insurance Corporations

Sec.

83-47-1. Declaration of purpose.
83-47-3. Formation of corporation; contents and approval of articles of incorporation.
83-47-5. Election of board of directors; membership in corporation; termination of membership; adoption of bylaws.
83-47-7. Establishing minimum capital and reserve; enforcement by injunction or mandamus.
83-47-9. Dues, fees and assessments; separate classes and groupings for fixing assessments of members; premium taxes.
83-47-11. Liability of members for debts of corporation; exemption of private property from execution.
83-47-13. Annual statement.
83-47-15. Investigation of affairs of corporation; access to books and documents; summoning and examining witnesses under oath.
83-47-17. Dissolution or liquidation of corporation.
83-47-19. Declaration of charitable status; exemption from taxation.
83-47-21. Conversion of nonprofit and nonshare corporations into nonprofit medical liability insurance corporations.
83-47-23. Nonprofit medical liability insurance corporations not covered by insurance guaranty association law.
83-47-25. Procedure for converting nonprofit medical liability insurance corporation to stock insurance corporation.

### § 83-47-1. Declaration of purpose.

The public health and welfare requires the adoption of this chapter providing for the organization and operation of nonprofit medical liability insurance corporations.

**SOURCES: Laws, 1977, ch. 491, § 1, eff from and after passage (approved April 15, 1977).**

#### RESEARCH REFERENCES

**Practice References.** Business Law Monographs, Volume IN2 — Casualty and Liability Insurance (Matthew Bender).

**Law Reviews.** Checking Up On the Medical Malpractice Liability Insurance Crisis in Mississippi: Are Additional Tort Reforms the Cure?, 73 Miss. L.J. 1001 (2004).

Hurricane Katrina Special Edition: Revamping the Wind Pool, 77 Miss. L.J. 795, Spring, 2008.

### § 83-47-3. Formation of corporation; contents and approval of articles of incorporation.

Any seven (7) or more physicians licensed to practice in Mississippi who are residents of this state, may form a nonprofit corporation under this chapter for the purpose of providing medical, professional, general and other liability insurance to health care providers, health care facilities and managed care organizations in Mississippi and any other state or jurisdiction. The term "health care provider," when used in this chapter, shall mean a physician, dentist, pharmacist, osteopath, psychologist, podiatrist, optometrist, chiropractor, nurse, medical technician or other health care provider licensed by the State of Mississippi or any other state or jurisdiction. The term "health care facility," when used in this chapter, shall mean a medical clinic, nursing home, outpatient surgical center, laboratory, pharmacy, dialysis clinic, hospital or other health care facility licensed, if necessary, by the State of Mississippi or any other state or jurisdiction. The term "managed care organization," when used in this chapter, shall mean a health maintenance organization (HMO), individual practice association (IPA), preferred provider organization (PPO), competitive medical plan (CMP), exclusive provider organization (EPO), integrated delivery system (IDS), independent physician/provider organization (IPO), management service organization (MSO), physician hospital/provider organization (PHO) and any other type of managed care organization. Members of the corporation shall consist of only individuals under contracts which entitle such individuals to medical liability insurance. Health care facilities and managed care organizations need not be owned by or comprised of members of the corporation in order to be insured by the corporation. All such corporations shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein. Such a corporation may be formed under this chapter in the following manner:

(a) The proposed incorporators shall subscribe articles of incorporation in which shall be stated:

(i) The proposed corporate name of the corporation, which shall not so closely resemble the name of any other corporation already transacting business in this state as to mislead the public or lead to confusion;

(ii) The domicile of the proposed corporation;

(iii) The names and post office addresses of the incorporators;

(iv) The fact that application for charter is being made under this chapter and the corporation proposed to operate under and subject to the provisions of this chapter;

(v) The purposes of the corporation.

(b) Such articles of incorporation shall be filed with the Commissioner of Insurance, who shall refer the same to the Attorney General for his opinion as to whether the same meet the requirements of this chapter and are not otherwise violative of the Constitution or laws of this state or of the United States. The Attorney General shall examine the same and endorse his opinion thereon and return the same to the Commissioner of Insurance for approval. The Commissioner of Insurance shall (if the same be approved by the Attorney General) thereupon endorse his certificate of approval upon such articles of incorporation, record the same in his office, and refer the same to the office of the Secretary of State to be there recorded, whereupon said corporation shall become and be considered an existing entity. The articles of incorporation as thus approved and recorded shall be and constitute the charter of incorporation of such corporation. It shall not be necessary that such charter be published, nor shall it be necessary that it be recorded in the office of the chancery clerk.

**SOURCES: Laws, 1977, ch. 491, § 2; Laws, 1995, ch. 372, § 1, eff from and after passage (approved March 15, 1995).**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the third sentence of the introductory paragraph. The words "integrated delivery system (EDS)" were changed to "integrated delivery system (IDS)". The Joint Committee ratified the correction at its May 20, 1998, meeting.

### RESEARCH REFERENCES

**ALR.** Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

**Am Jur.** 44A Am. Jur. 2d, Insurance § 1419.

**CJS.** 45 C.J.S., Insurance § 1206.

## § 83-47-5. Election of board of directors; membership in corporation; termination of membership; adoption of bylaws.

Corporations organized under this chapter shall not have capital stock, but shall have members as prescribed and contemplated by the terms and provisions of this chapter; and such members shall have the privileges provided for in this chapter. The subscribers to the articles of incorporation as the organizers of the corporation shall have power to elect the first board of directors, who shall serve for the terms prescribed in the next sentence of this section, or until their successors are elected and qualified. One-third (⅓) of the members of the first board of directors shall be elected for a term of one (1) year, one-third (⅓) for a term of two (2) years, and one-third (⅓) for a term of three (3) years. Thereafterwards, directors shall be elected for terms of three (3) years. Provisions shall be made for subsequent elections of directors, including the time and place of such elections and notice thereof to the membership by (a) resolution of the directors entered upon the minutes not less than sixty (60) days before such election, designating the time and place of such election, such minutes to be open to the membership as hereinafter provided, or (b) by the time and place of such election being fixed by resolution of the directors, and notice thereof being mailed to the members at least fifteen (15) days before the time fixed for such election. All minutes of the corporation with respect to the time and place fixed for any such election of directors shall be open to members at all reasonable times, but no notice of elections shall be necessary, other than as herein provided. Each member shall be entitled to one (1) vote in the election of directors. It shall be the duty of the directors to provide for elections as the terms of office of directors expire, and it shall be the duty of the Commissioner of Insurance as a part of his supervisory jurisdiction over such corporations to see that the directors faithfully perform this duty. If such directors shall fail to so provide for the election of directors, it shall be the duty of the Commissioner of Insurance to report this fact to the membership of the corporation and himself call a meeting of the membership for the election of directors; and the corporation shall forthwith, upon demand of the commissioner, reimburse him for all expenses incurred in the performance of these duties. A majority vote of the members present in person (or by proxy, if proxy be provided for) and voting shall be required and shall be sufficient for the election of directors.

The membership of the corporation shall consist of any individual who has applied for, or been granted, a license to practice medicine in the State of Mississippi, or any other state or jurisdiction, provided he has first applied for membership on the form prescribed by the board of directors and paid the requisite fees, charges and premiums in advance therefor, and agreed to comply with and be bound by the charter and bylaws and amendments thereto, and the rules, regulations and guidelines adopted from time to time by the board of directors or any committee authorized by the board of directors to so act.

No person may own more than one (1) membership in the corporation, nor shall any member be entitled to more than one (1) vote upon any matter submitted to a vote at the meeting of the members.

Membership shall not be granted until a membership certificate in the form prescribed by the board of directors shall have been duly issued.

The event of (a) death, or (b) revocation of license to practice medicine, or (c) nonpayment of membership fees, dues, assessments or premiums, or (d) failure to comply with and abide by all provisions of the charter and bylaws and amendments thereto, and the rules, regulations and guidelines adopted from time to time by the board of directors or (e) termination of insurance with the corporation for any reason, shall operate ipso facto to terminate membership in the corporation, and all interest of any such member in the assets of the corporation shall then and thereby terminate and cease, except for the right to receive benefits provided for under contracts or the bylaws of the corporation.

The directors shall have power to adopt bylaws, elect officers and manage the affairs of the corporation. They shall also have the power to determine whether voting in the election of directors may be done by proxy and, if so, the manner and method thereof.

**SOURCES: Laws, 1977, ch. 491, § 3; Laws, 1995, ch. 372, § 2, eff from and after passage (approved March 15, 1995).**

## § 83-47-7. Establishing minimum capital and reserve; enforcement by injunction or mandamus.

(1) Each corporation established under the provisions of this chapter shall furnish to the commissioner of insurance all information that he may request concerning the number of members of any such corporation and the type of practice of each such member. After considering the number of members and the type of practice of each such member, the commissioner of insurance shall require a minimum capital of Five Hundred Thousand Dollars ($500,000.00) and a minimum surplus of Five Hundred Thousand Dollars ($500,000.00) for

such corporation. All dues, fees and assessments to any member of the corporation shall be set and maintained at the lowest possible cost subject to sound business practice and shall be subject to review and approval of the commissioner of insurance. No corporation established under the provisions of this chapter shall transact any other business than that specified in its charter and articles of incorporation; and it shall not begin operation until it has fully complied with all rules and regulations promulgated by the commissioner of insurance with respect to such corporations and until it has established the capital and reserve set for it by the commissioner.

(2) When necessary to effect the purposes of this section, in addition to all other remedies in law or equity, the attorney general and commissioner of insurance may be and are hereby authorized to petition the chancery court of the county in which a corporation established under this chapter is domiciled for a mandamus or injunction to prevent any violation of the provisions of this section, or the continuance of any such violation, or to enforce compliance herewith. The court is hereby vested with authority to entertain jurisdiction on any such petition to determine the cause and to issue such process as may be necessary to accomplish the purposes of this section.

**SOURCES: Laws, 1977, ch. 491, § 4, eff from and after passage (approved April 15, 1977).**

## § 83-47-9. Dues, fees and assessments; separate classes and groupings for fixing assessments of members; premium taxes.

Each member shall pay all dues, fees and assessments in such amounts as may be established from time to time by the resolution of the board of directors. The board of directors shall have the authority to provide for separate and distinct classes of insurance and groupings of members and insureds and to fix assessments and premiums at varying and different amounts for the various classes. No member or insured shall refuse or neglect to pay his or its assessment or premium because the amount thereof differs or varies from the amount of the assessment or premium of members in other classes or groupings. The board of directors shall endeavor to establish and fix assessments and premiums for the various classes and groupings which are reasonable in amount, relative to the benefits to be received by those members and insureds within the classes and groupings involved, and the action of the board of directors in so doing shall be conclusive and final. Each member shall also pay all obligations which may, from time to time, become due and payable by such member to the corporation as and when the same shall become due and payable. Such fees, assessments and premiums required of members and insureds shall contain an amount sufficient to pay three percent (3%) premium tax, the same as levied on all other domestic nonprofit insurance corporations. Such premium taxes shall be collected and paid into the treasury by the State Tax Commission.

**SOURCES: Laws, 1977, ch. 491, § 5; Laws, 1982, ch. 351, § 18; Laws, 1995, ch. 372, § 3, eff from and after passage (approved March 15, 1995).**

**Editor's Note** — Section 20 of ch. 351, Laws of 1982, effective July 1, 1982, provides as follows:

"SECTION 20. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under any section contained herein prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective, or shall thereafter be begun; and the provisions of any section contained herein are expressly continued in full force, effect and operation for the purpose of the assessment and collection of any taxes due or accrued thereunder prior to the date on which this act becomes effective, or the filing of reports, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

## § 83-47-11. Liability of members for debts of corporation; exemption of private property from execution.

The private property of the members of the corporation shall be exempt from the execution for the debts of the corporation, and no member shall be individually liable or responsible for any debts or liabilities of the corporation.

**SOURCES: Laws, 1977, ch. 491, § 6, eff from and after passage (approved April 15, 1977).**

## § 83-47-13. Annual statement.

Every such corporation shall annually, on or before the first day of March, file in the office of the commissioner of insurance a statement verified by at least two (2) of the principal officers of said corporation, showing its condition on the thirty-first day of December of the preceding year, which shall be in such form and shall contain such matters as the commissioner shall prescribe.

**SOURCES: Laws, 1977, ch. 491, § 7, eff from and after passage (approved April 15, 1977).**

## § 83-47-15. Investigation of affairs of corporation; access to books and documents; summoning and examining witnesses under oath.

The commissioner of insurance may appoint any deputy or examiner or other person who shall have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, employees or other persons in relation to the affairs, transactions and conditions of the corporation.

**SOURCES: Laws, 1977, ch. 491, § 8, eff from and after passage (approved April 15, 1977).**

## § 83-47-17. Dissolution or liquidation of corporation.

Any dissolution or liquidation of a corporation, subject to the provisions of this chapter, shall be conducted under the supervision of the commissioner of insurance, who shall have all power with respect thereto under the provisions of law with respect to the dissolution and liquidation of insurance companies.

**SOURCES: Laws, 1977, ch. 491, § 9, eff from and after passage (approved April 15, 1977).**

## § 83-47-19. Declaration of charitable status; exemption from taxation.

Every corporation organized pursuant to, or subject to, the provisions of this chapter is hereby declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation, except from the premium tax levied in accordance with the provisions of this chapter and ad valorem taxes upon real estate and motor vehicles owned by it.

**SOURCES: Laws, 1977, ch. 491, § 10; Laws, 1978, ch. 441, § 10, eff from and after July, 1978.**

## § 83-47-21. Conversion of nonprofit and nonshare corporations into nonprofit medical liability insurance corporations.

Any corporation heretofore or hereafter organized and operating under Chapter 11, Title 79, Mississippi Code of 1972, desiring to become a nonprofit corporation of the kind and character described in this chapter, and to operate under and pursuant to the terms of this chapter, may convert its organization into such nonprofit corporation under this chapter in the following manner, to wit:

(a) File a written application with the commissioner of insurance annexing thereto copies of (i) its articles of incorporation or new or amended articles of incorporation; (ii) its bylaws; (iii) its form of contract between the corporation and members, showing the terms under which medical liability insurance is to be furnished to members; (iv) its contracts with members, showing a table of assessments and the benefits to which members are entitled; and (v) a financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital, the name or names of each contributor, and the terms of each contribution.

(b) Submit any further data or evidence as may be required by the commissioner.

(c) The commissioner shall refer the corporation's articles of incorporation to the attorney general for his opinion as to whether the same meet the requirements of this chapter. The attorney general shall, if in order to do so, endorse his approval thereon and return the same to the commissioner of insurance. The commissioner shall thereupon endorse upon said articles of incorporation his certificate of approval, whereupon said corporation shall be deemed to be converted under and existing and operating pursuant to the terms of this chapter. The articles of incorporation bearing such approval of the attorney general and the commissioner shall be recorded in the offices of the commissioner of insurance and of the secretary of state in like manner as in this chapter provided for recording the articles of incorporation of a corporation organized under this chapter in the first instance.

**SOURCES: Laws, 1977, ch. 491, § 11, eff from and after passage (approved April 15, 1977).**

## § 83-47-23. Nonprofit medical liability insurance corporations not covered by insurance guaranty association law.

The organization as created under the authority of this chapter shall in no manner be covered under or included in the provisions of Sections 83-23-101 through 83-23-135.

**SOURCES: Laws, 1977, ch. 491, § 12, eff from and after passage (approved April 15, 1977).**

### RESEARCH REFERENCES

**Practice References.** Business Law Monographs, Volume IN2 — Casualty and Liability Insurance (Matthew Bender).

## § 83-47-25. Procedure for converting nonprofit medical liability insurance corporation to stock insurance corporation.

(1) A corporation organized under this chapter may become a stock insurance corporation under such plan and procedure as may be approved by the Commissioner of Insurance.

(2) The Commissioner of Insurance shall approve any such plan or procedure if:

(a) It is equitable to the corporation's members;

(b) It is subject to approval by vote of not less than three-fourths (¾) of the corporation's current members voting thereon in person or by proxy at a meeting of members called for the purpose pursuant to such reasonable notice and procedure as may be approved by the Commissioner of Insurance; right to vote may be limited to members who hold policies at the time of the vote and whose policies have been in force for not less than one (1) policy year;

(c) The equity of each member in the corporation is determinable under a fair formula approved by the Commissioner of Insurance, which such equity shall be based upon not less than the corporation's entire surplus as reported in the corporation's annual statement to the Commissioner of Insurance, after deducting borrowed surplus funds, plus all nonadmitted assets;

(d) The members entitled to participate in the purchase of stock or distribution of assets shall include all current members who hold policies at the time of the vote and whose policies have been in force for not less than one (1) policy year;

(e) The plan gives to each member, as specified in subsection (2)(d) of this section, a preemptive right to acquire his proportionate part of all of the proposed capital stock of the corporation, within a designated reasonable period, and to apply upon the purchase thereof the amount of his equity in the corporation as determined under subsection (2)(c) of this section;

(f) Shares are so offered to members at a price not greater than to be thereafter offered to others;

(g) The plan provides for payment to each member not electing to apply his equity in the corporation for, or upon, the purchase price of stock to which the member is preemptively entitled of cash in the amount of his equity not so used for the purchase of stock, and which case payment, together with stock so purchased, if any, shall constitute full payment and discharge of the member's equity as a member of such corporation; and

(h) The plan, when completed, would provide for the converted corporation paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance, together with surplus funds in amount not less than one half (½) of such required capital.

(3) Once conversion under this section is complete, the converted corporation shall no longer be governed by this chapter and shall be governed by the provisions of the insurance laws of this state applicable to general liability insurers.

**SOURCES: Laws, 1995, ch. 372, § 4, eff from and after passage (approved March 15, 1995).**

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 70-73, 96-101.

**CJS.** 44 C.J.S., Insurance §§ 153 et seq.

## CHAPTER 48

## Medical Malpractice Insurance Availability Act

Sec.
83-48-1 through 83-48-7. Repealed
83-48-9. Repeal of Sections 83-48-1 through 83-48-7.

### § 83-48-1 through 83-48-7. Repealed.

Repealed by operation of law effective July 31, 2008.

§ 83-48-1. [Laws, 2003, ch. 560, § 1; reenacted without change, Laws, 2005, ch. 539, § 1; reenacted without change, Laws, 2006, ch. 567, § 1, eff from and after passage (approved Apr. 24, 2006.)]

§ 83-48-3. [Laws, 2003, ch. 560, § 2; reenacted without change, Laws, 2005, ch. 539, § 2; reenacted without change, Laws, 2006, ch. 567, § 2, eff from and after passage (approved Apr. 24, 2006.)]

§ 83-48-5. [Laws, 2003, ch. 560, § 3; reenacted and amended, Laws, 2005, ch. 539, § 3; reenacted and amended, Laws, 2006, ch. 567, § 3; Laws, 2009, ch. 563, § 15, eff from and after passage (approved May 13, 2009.)]

§ 83-48-7. [Laws, 2003, ch. 560, § 4; reenacted without change, Laws, 2005, ch. 539, § 4; reenacted without change, Laws, 2006, ch. 567, § 4, eff from and after passage (approved Apr. 24, 2006.)]

**Editor's Note** — Former § 83-48-1 provided the short title for Chapter 48, Title 83.

Former § 83-48-3 provided that the purpose of the chapter was to provide a temporary market of last resort to make necessary medical malpractice insurance available for certain hospitals or other health care facilities and licensed health care providers.

Former § 83-48-5 created the Medical Malpractice Insurance Availability Plan.

Former § 83-48-7 created an advisory council to serve the Tort Claims Board for matters pertaining to the Medical Malpractice Coverage Availability Plan.

### § 83-48-9. Repeal of Sections 83-48-1 through 83-48-7.

Sections 83-48-1, 83-48-3, 83-48-5 and 83-48-7, Mississippi Code of 1972, shall stand repealed from and after the transfer of the plan's assets and liabilities as provided in Section 83-48-5(6)(i).

**SOURCES: Laws, 2005, ch. 539, § 7; reenacted and amended, Laws, 2006, ch. 567, § 5, eff from and after passage (approved Apr. 24, 2006.)**

**Editor's Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in a statutory reference. The reference "83-48-6(i)" was changed to "83-48-5(6)(i)". The Joint Committee ratified the correction at its May 31, 2006, meeting.

This section provided that Sections 84-48-1, 84-48-3, 84-48-5 and 84-48-7 would stand repealed from and after the transfer of the assets and liabilities of the Medical Malpractice Insurance Availability Plan as provided in Section 83-48-5(6)(i). The Tort Claims Board accepted a proposal in May 2008 to sell the Plan to a private entity, and the plan's assets and liabilities were transferred to the private entity by the end of July 2008.

# CHAPTER 49

## Legal Expense Insurance

Sec.
83-49-1. Purposes and construction of chapter.
83-49-3. Persons to whom chapter applies.
83-49-5. Definitions.
83-49-7. License required for sponsor other than insurer; fee; disclosure of business relationships; denial of license.
83-49-9. Investigation of sponsor license applicants; qualifications for license; notice of denial; hearing.
83-49-11. Revocation, suspension or refusal to renew sponsor's or representative's license; grounds; procedure; alternative penalties; subsequent application; review.
83-49-13. Subscription contract; required contents; referrals to attorneys; filing and approval of contracts.
83-49-15. Contracts for additional insurance or administrative services; approval.
83-49-17. Approval of underwriting rules and premiums; factors for consideration; conformity with state laws.
83-49-19. Advertising standards.
83-49-21. Provisions of §§ 83-5-29 through 83-5-51 applicable to plan sponsors.
83-49-23. Capitalization of sponsors other than insurers; impairment.
83-49-25. Annual report; contents.
83-49-27. Retention of records; inspection and report; expenses.
83-49-29. Hearings and proceedings to be in conformity with §§ 83-17-123 et seq.
83-49-31. Injunctive relief against plans in violation of chapter; appointment of receivers; enforcement of criminal laws.
83-49-33. Venue provisions applicable to sponsors.
83-49-35. Rules and regulations.
83-49-37. Insurers to be in conformity with this chapter and other laws.
83-49-39. Investment of funds.
83-49-41. Disposition of deposits.
83-49-43. When subscription contracts may first be issued.
83-49-45. Tax imposed on premiums; collection and enforcement.
83-49-47. Agent or representative of sponsor; license required; fee; investigation; denial; grounds for issuance.
83-49-49. Reserve.

### § 83-49-1. Purposes and construction of chapter.

The purposes of this chapter are to provide for legal expense insurance by the registration of prepaid legal services plans, to promote access to quality legal services at the lowest possible price, and to regulate the development and operation of prepaid legal services plans, and it is the intent of this legislature that this chapter be interpreted as liberally as necessary to accomplish these purposes.

**SOURCES: Laws, 1983, ch. 474, § 1, eff from and after July 1, 1983.**

## JUDICIAL DECISIONS

**1. Arbitration clauses.**

Grant of partial summary judgment in favor of the individuals and against the corporation in an action involving prepaid legal services was proper where no valid, binding arbitration agreement existed in the prepaid legal expense agreement, Miss. Code Ann. § 83-49-1 et seq.; in essence, there was no clear showing that the parties had agreed to arbitration. Pre-Paid Legal Servs. v. Battle, 873 So. 2d 79 (Miss. 2004), cert. denied, — U.S. —, 125 S. Ct. 409, 160 L. Ed. 2d 321 (2004).

## § 83-49-3. Persons to whom chapter applies.

The provisions of this chapter shall apply to all persons, groups, fraternal or benevolent organizations, including, but not limited to, insurers, corporations, partnerships, trusts, labor, craft or other unions, or any other entities who propose to operate or are operating or participating in the operation of a prepaid legal services plan as such a plan is hereinafter defined.

**SOURCES: Laws, 1983, ch. 474, § 2, eff from and after July 1, 1983.**

## § 83-49-5. Definitions.

In this chapter, the following terms shall have the following meanings:

(a) "Sponsor" means any insurer, as defined in this section, or any other corporation organized for the exclusive purpose of establishing and operating prepaid legal services plans.

(b) "Prepaid legal services plan" or "plan" means any arrangement whereby responsibility is undertaken to provide or arrange for, or to pay for or reimburse any part of the cost of, any legal services for a consideration consisting in part of prepaid or periodic charges or dues; but the provisions of this chapter shall not apply to the benefits available under automobile club membership contracts and automobile liability insurance policies which supply limited legal services or reimbursement for legal services in automobile-related matters under certificates of authority issued by the Insurance Commissioner, or to any legal aid or other legal services program for the indigent, or to limited legal services supplied by professional education associations to their members, or to any employer-employee legal services plan which is excluded from the provisions of this chapter by the provisions of the Federal Employee Retirement Income Security Act of 1974, or any amendments thereto.

(c) "Legal services" means any services normally provided by an attorney, as well as the payment of court costs and related expenses incurred in the exercise of any right; but not including the payment of fines, penalties, judgments or assessments. "Legal services" shall not include any service provided by an attorney in regard to a tort action.

(d) "Advertising" means any communication, other than a solicitation, as hereinafter defined, to the public or any segment thereof by means of radio, television, newspaper, magazine, periodical, brochure, pamphlet, circular, or any other means, the apparent purpose or reasonable effect of which would be to convey information purporting to relate to or describe legal rights, legal services, attorneys or prepaid legal services plans.

"Solicitation" means any communication, written or oral, in person, or by means of telephone, radio, television, newspaper, magazine, periodical, brochure, circular, or otherwise, of any offer of coverage in a prepaid legal services plan, or invitation, or request to enroll in a prepaid legal services plan, or attempt to obtain consideration for the coverage of a prepaid legal services plan, or any other device, the apparent purpose or reasonable effect of which would be to induce the recipient thereof to enroll in, or pay any consideration for the coverage provided by, a prepaid legal services plan.

(e) "Commissioner" means the Insurance Commissioner of the State of Mississippi.

(f) "Subscriber" means any person who has been enrolled in a prepaid legal services plan and is entitled to receive the benefits provided in the plan.

(g) "Subscription contract" means any contract signed by an authorized representative of a prepaid legal services plan and an individual or an authorized representative of his group or employer or labor union or other entity with which he is affiliated, under which the individual becomes a subscriber to the plan.

(h) "Insurer," as defined in this chapter means an insurer licensed to transact life or casualty insurance in this state.

**SOURCES: Laws, 1983, ch. 474, § 3; Laws, 1997, ch. 307, § 7; Laws, 2009, ch. 336, § 1, eff from and after passage (approved Mar. 16, 2009.)**

**Amendment Notes** — The 2009 amendment inserted "or to limited legal services supplied by professional education associations to their members" in (b).

**Federal Aspects** — Federal Employee Retirement Income Security Act of 1974, see 29 USCS §§ 1001 et seq.

## § 83-49-7. License required for sponsor other than insurer; fee; disclosure of business relationships; denial of license.

(1) No person other than an insurer as defined herein shall act as a sponsor nor enter into any contract with an individual person or persons whereby such person or persons become subscribers to a prepaid legal services plan without first having obtained a license from the commissioner to act as sponsor of prepaid legal services in this state.

(2) The annual license fee shall be One Hundred Fifty Dollars ($150.00). The fee for said license shall be paid to the commissioner for the use of the state on or before March 1 of each year.

(3) Before any licensee changes his address, he shall return his license to the commissioner who shall endorse the license indicating the change.

(4) The person to whom the license or the renewal thereof may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner shall have authority, at any time, to require the applicant to disclose fully the identity of all stockholders, partners, officers and employees, and he may, in his discre-

tion, refuse to issue or renew a license in the name of any firm, partnership or corporation if he is not satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

**SOURCES: Laws, 1983, ch. 474, § 4, eff from and after July 1, 1983.**

**Cross References** — Definition of "insurer", see § 83-49-5.

Revocation, suspension or refusal to renew license, see § 83-49-11.

Capitalization requirements for sponsors other than insurers as condition of license; see § 83-49-23.

License or representative of sponsor, see § 83-49-47.

Penalty for perjury, see § 97-9-61.

## § 83-49-9. Investigation of sponsor license applicants; qualifications for license; notice of denial; hearing.

Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and shall issue a license if he finds the applicant is qualified in accordance with this chapter. If the commissioner does not so find, he shall, within ninety (90) days after he has received such application, so notify the applicant and, at the request of the applicant, give the applicant a full hearing.

The commissioner shall issue or renew a license as may be applied for when he is satisfied that the person to be licensed:

(a) Is competent and trustworthy and intends to act in good faith as a sponsor of prepaid legal services plans in this state;

(b) Has a good business reputation and has had experience, training or education so as to be qualified to act as a sponsor of prepaid legal services plans; and

(c) If a corporation is incorporated under the laws of this state or a foreign corporation authorized to transact business in this state.

**SOURCES: Laws, 1983, ch. 474, § 5, eff from and after July 1, 1983.**

**Cross References** — Capitalization required of sponsor other than insurer as condition to issuance of license, see § 83-49-23.

Investigation of applicants for license as agent or representative of sponsor, see § 83-49-47.

## § 83-49-11. Revocation, suspension or refusal to renew sponsor's or representative's license; grounds; procedure; alternative penalties; subsequent application; review.

The commissioner may revoke or suspend or refuse to renew the license of any sponsor or representative of such sponsor when and if after investigation the commissioner finds that:

(a) Any license issued to such sponsor or representative of such sponsor was obtained by fraud;

(b) There was any misrepresentation in the application for the license;

(c) The sponsor or representative of such sponsor has otherwise shown itself untrustworthy or incompetent to act as a sponsor or representative of such sponsor;

(d) Such sponsor or representative of such sponsor has violated any of the provisions of this chapter or of the rules and regulations of the commissioner;

(e) The sponsor or representative of such sponsor has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys entrusted to the sponsor or representative of such sponsor in its fiduciary capacity belonging to an insurer or insured;

(f) The sponsor or representative of such sponsor is found to be in an unsound condition or in such condition as to render the future transaction of business in this state hazardous to the public; or

(g) The sponsor or representative of such sponsor is found guilty of fraudulent, deceptive, unfair or dishonest practices as defined in Section 83-5-35 or 83-5-45, Mississippi Code of 1972, or has been convicted of a felony.

Before any license shall be refused, suspended, revoked or the renewal thereof refused hereunder, the commissioner shall give notice of his intention so to do, by certified mail, return receipt requested, to the applicant for or holder of such license and to any sponsor whom such representative represents or who desires that he be licensed, and shall set a date not less than twenty (20) days from the date of mailing such notice when the applicant or licensee and a duly authorized representative of the sponsor may appear to be heard and produce evidence. In the conduct of such hearing, the commissioner or any regular salaried employee specially designated by him for such purposes shall have power to administer oaths, to require the appearance of and examine any person under oath, and to require the production of books, records or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of such hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office; and notice of the findings shall be sent by certified mail to the applicant or licensee and the sponsor concerned.

No licensee whose license has been revoked hereunder shall be entitled to file another application for a license as a sponsor or a representative of any sponsor within one (1) year from the effective date of such revocation. Such application, when filed, may be refused by the commissioner unless the applicant shows good cause why the revocation of his license shall not be deemed a bar to the issuance of a new license.

In lieu of revoking, suspending or refusing to renew the license for any of the causes enumerated in this section, after hearing as herein provided, the commissioner may place the sponsor on probation for a period of time not to exceed one (1) year, or may fine such sponsor not more than One Thousand Dollars ($1,000.00) for each offense, or both, when in his judgment he finds that the public interest would not be harmed by the continued operation of the sponsor. The amount of any such penalty shall be paid by such sponsor to the commissioner for the use of the state. At any hearing provided by this section, the commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered such oath, shall be subject to the penalty of perjury.

Any action of the commissioner taken pursuant to the provisions of this section shall be subject to review as may be provided in Section 83-17-125.

**SOURCES: Laws, 1983, ch. 474, § 6, eff from and after July 1, 1983.**

**Editor's Note —** Section 83-17-125, referenced in the last paragraph, was repealed by Laws of, 2001, ch. 510, § 34, effective from and after January 1, 2002.

**Cross References —** Application of §§ 83-5-29 through 83-5-51 to sponsors, see § 83-49-21.

Capitalization requirements of sponsors other than insurers as condition of license, see § 83-49-23.

Promulgation of rules and regulations, see § 83-49-35.

Penalty for perjury, see § 97-9-61.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any felony violation, see § 99-19-73.

## RESEARCH REFERENCES

**Am Jur.** 14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

## § 83-49-13. Subscription contract; required contents; referrals to attorneys; filing and approval of contracts.

(1) Any sponsor of any prepaid legal services plan, or authorized representative thereof, may enter into a subscription contract with any person, or with any person's employer, or with any other person or group acting in his or its behalf; provided, however, that:

(a) No such subscription contract shall be written for a period longer than three (3) years; and

(b) In the case of subscription contracts issued to groups, no member of the group shall be bound by the subscription contract unless he indicates in writing to the group no earlier than ten (10) days after the date on which he has received effective notice of the terms and benefits of the plan and the intention of his group to contract for such plan that he does wish to become a subscriber and to be bound by the subscription contract. The notice received by such member shall contain, without limitation, the provisions itemized in subsection (2) hereinbelow.

(2) Every subscription contract shall be in writing and shall contain the following provisions:

(a) A brief statement of the plan's financial structure, including a statement of the amount of any premiums, charges or dues to be charged or currently being charged and the manner in which such amount is to be paid;

(b) A statement of the amount of benefits, reimbursement or indemnity to be furnished to each subscriber, and the period during which it will be furnished; and, if there are exceptions, reductions, exclusions, limitations or restrictions of such benefits reimbursement or indemnity, a detailed statement of such exceptions, reductions, exclusions, limitations or restrictions;

(c) A statement of the terms and conditions upon which the subscription contract may be cancelled or otherwise terminated by the sponsor or by the subscriber or by his employer or by his group. Provided, that any such cancellation or termination by the sponsor shall not become effective unless accomplished in accordance with the provisions of Sections 83-11-5, 83-11-9, 83-11-13, 83-11-15, 83-11-17, 83-11-19 and 83-11-21;

(d) A statement describing the applicability or nonapplicability of the benefits of the plan to the family dependents of the subscriber;

(e) A statement of the period of grace which will be allowed the subscriber or his employer or group for making any payment due under the subscription contract, which period shall not be less than twenty (20) days;

(f) A statement describing a procedure for settling disputes between or among the sponsor, participating or staff attorneys, and the subscribers;

(g) A statement that the subscription contract includes the endorsements thereon and attached papers, if any, and contains the entire contract; and

(h) A statement that no statements by the subscriber or his employee or group in the application for the contract shall void the subscription contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such subscription contract.

(3) A sponsor may provide a benefit plan which would provide only a telephone service for advice or consultation. Such telephone service shall not recommend a particular attorney to the subscriber.

(4) A sponsor may provide a benefit plan which would provide legal service including telephone advice or consultation which may recommend an attorney to the subscriber.

(5) Every subscriber shall be furnished a copy of his subscription contract, and every employer or other group shall be furnished a copy of the subscription contract signed by it.

(6) The sponsor shall be required to file a "specimen" copy of each subscription contract it uses, and a copy of its underwriting rules with the commissioner and a copy thereof shall also be sent to the Mississippi Bar by the sponsor. Such filings shall be approved by the commissioner before being used, however, such filings with the commissioner shall be deemed approved ninety (90) days after the date such filing is received by the commissioner, unless, prior to the expiration of said ninety-day period, the commissioner notified the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval. The commissioner shall require that all such subscription contracts shall be fair and reasonable, and shall not approve any subscription contracts or underwriting rules that are unfair or inequitable or contrary to the public policy of this state, or would, because such provisions are unclear or deceptively worded or encourage misrepresentation.

**SOURCES: Laws, 1983, ch. 474, § 7; Laws, 1997, ch. 442, § 1, eff from and after passage (approved March 25, 1997).**

**Cross References** — State bar association generally, see §§ 73-3-101 et seq.

### JUDICIAL DECISIONS

**1. Arbitration Clauses.**

Grant of partial summary judgment in favor of the individuals and against the corporation in an action involving prepaid legal services was proper where no valid, binding arbitration agreement existed in the prepaid legal expense agreement, Miss. Code Ann. § 83-49-1 et seq.; in essence, there was no clear showing that the parties had agreed to arbitration. Pre-Paid Legal Servs. v. Battle, 873 So. 2d 79 (Miss. 2004), cert. denied, — U.S. —, 125 S. Ct. 409, 160 L. Ed. 2d 321 (2004).

## § 83-49-15. Contracts for additional insurance or administrative services; approval.

(1) The sponsor of any prepaid legal services plan, or authorized representative thereof, may contract with any company licensed to transact life or casualty insurance in this state, under which contracts such company agrees, for a consideration consisting of a specified premium to assume the monetary obligations of the plan to provide or pay for the legal services covered by the subscription contracts issued under such plan, upon the failure of the plan itself to meet such obligations within a specified period. The duration of such contracts shall not be longer than three (3) years, and every such contract shall be filed with and subject to the approval of the commissioner for the fairness of its terms and premiums. The contracts shall be deemed approved ninety (90) days after date of filing with the commissioner, unless, prior to the expiration of such ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval. Any sponsor entering into such contracts shall fairly disclose to all subscribers affected by them the nature and extent of the extra protection provided by them. Any plan having lawful access to any other source of funds besides the premiums collected, which may be used to meet the obligations of the plan under its subscription contracts, shall make similar fair disclosure to affected subscribers.

(2) Any sponsor of any prepaid legal services plan, or authorized representative thereof, may contract with any person to provide administrative services necessary to the administration of the plan and the subscription contracts issued thereunder. The duration of such contracts shall not be longer than three (3) years, and every such contract shall be filed with and subject to the approval of the commissioner as to the fairness of its terms. The contracts shall be deemed approved ninety (90) days after the date of filing with the commissioner unless, prior to the expiration of such ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval.

**SOURCES: Laws, 1983, ch. 474, § 8; Laws, 1997, ch. 307, § 8, eff from and after July 1, 1997.**

### § 83-49-17. Approval of underwriting rules and premiums; factors for consideration; conformity with state laws.

(1) No sponsor of any prepaid legal services plan, or authorized representative thereof, shall enter into any contract with subscribers unless and until the sponsor has filed with the commissioner a copy of its underwriting rules and a full schedule of the rates, premiums or membership fees to be charged to the subscribers. These filings shall be deemed to be approved by the commissioner ninety (90) days after the date of filing with the commissioner, unless, prior to the expiration of the ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval.

(2) In considering whether or not to approve a given rate schedule, the commissioner shall consider the following factors:

(a) Whether the rates are adequate to insure that all the benefits contracted for will be supplied;

(b) Whether the rates are excessive;

(c) Whether the rates are unfairly discriminatory; and

(d) Whether the rates are otherwise contrary to the laws or public policies of this state.

(3) In determining whether the rates to be charged are excessive, unfairly discriminatory, inadequate or otherwise contrary to the laws or public policies of this state, consideration shall be given to the past and prospective loss and countrywide expense experience, to all factors reasonably attributable to the class of risk, to a reasonable margin for profit and contingencies, to subscribers' or policyholders' dividends, savings or unabsorbed premium deposits allowed or returned by an insurer or sponsor to its policyholders, members or subscribers and investment income.

The systems of expense provisions included in the rates for use by any insurer, group of insurers or sponsor may differ from those of other insurers, group of insurers or sponsors, to reflect the requirements of the operating method of any insurer, group of insurers or sponsors with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which the subdivision or combination of separate expense provisions are applicable.

Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards, or in experience, or in expense provisions, or in all three (3) factors.

Except to the extent necessary to meet the provisions of subsection (1) of this section, uniformity among insurers or sponsors in any matters within the scope of this section is neither required nor prohibited.

(4) Insurers licensed to transact life or casualty insurance in this state are required to comply with the requirements of this section if they sell or offer for sale policies of prepaid legal services plans of sponsors licensed to operate prepaid legal services plans in this state. Provided, that nothing contained herein shall be deemed to relieve any insurer authorized to transact life or casualty insurance in this state from complying with the requirements of Title 83, Mississippi Code of 1972, and other laws of this state.

**SOURCES: Laws, 1983, ch. 474, § 9; Laws, 1997, ch. 307, § 9, eff from and after July 1, 1997.**

**Cross References** — When policies of insurance approved under this section may be issued by insurers, see § 83-49-43.

## § 83-49-19. Advertising standards.

All advertising and solicitation concerning prepaid legal services plans shall be conducted in a simple, dignified manner. Every item of advertising or solicitation shall conform with the following standards:

(a) The form and content of any advertisement or solicitation shall be accurate and shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed, or within a segment of the public to which such advertisement may be reasonably calculated to reach.

(b) All advertisements and solicitations shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implications or by familiarity with insurance terminology, shall not be used.

(c) Advertising and solicitation which include references to the legal rights or remedies of citizens shall be legally accurate.

(d) Advertising and solicitation which include references to the particular characteristics of one or more sponsors or prepaid legal services plans, or which compare one or more sponsors or prepaid legal services plans, shall be truthful and not misleading.

(e) No such advertising or solicitation shall contain the name, address, telephone number or any other identifying information about any attorney, and no such advertising or solicitation shall extol the alleged virtues or qualifications or point out the alleged shortcomings of any attorney, whether named or not.

**SOURCES: Laws, 1983, ch. 474, § 10, eff from and after July 1, 1983.**

**Cross References** — Inclusion of advertising materials in annual report, see § 83-49-25.

### § 83-49-21. Provisions of §§ 83-5-29 through 83-5-51 applicable to plan sponsors.

The provisions of Sections 83-5-29 through 83-5-51 applicable to "insurers" shall apply to sponsors as defined in this chapter and for the purpose of determining whether a violation of Sections 83-5-29 through 83-5-51 has occurred, a "sponsor" as defined in this chapter shall be deemed to be a "person" as used in Sections 83-5-29 through 83-5-51, whichever is applicable.

**SOURCES: Laws, 1983, ch. 474, § 11, eff from and after July 1, 1983.**

### § 83-49-23. Capitalization of sponsors other than insurers; impairment.

No license or renewal license under this chapter shall be issued to a sponsor other than an insurer as defined herein, unless such sponsor:

(a) Shall possess as minimum capital and thereafter maintain a minimum balance of at least Five Thousand Dollars ($5,000.00) in its capital accounts as shown in its annual report to the commissioner. Provided, the commissioner shall, in his discretion, require such higher amounts of capital as he deems necessary for the protection of the public;

(b) Shall deposit with the commissioner securities acceptable to the commissioner in the amount of Twenty-five Thousand Dollars ($25,000.00), or shall file with the commissioner a bond to be approved by the commissioner and made payable to the commissioner or his successors in office executed by such applicant as principal and by a corporate surety authorized to do business in this state in the penal sum of Twenty-five Thousand Dollars ($25,000.00), conditioned that the sponsor will conduct his business in accordance with the provisions of this chapter and the laws of this state, and that the sponsor will properly account for all moneys collected in connection therewith. Such bond shall remain in full force and effect until the surety is released from liability by the commissioner or until the bond is cancelled by the surety and no such bond shall be cancelled or terminated unless prior to such cancellation or termination thirty (30) days' written notice is filed with the commissioner; and

(c) Shall maintain at all times a surplus, after deduction of reserves and exclusive of capital, of not less than twice the amount of capital required by paragraph (a), provided, however, in no case shall such surplus required to be maintained exceed Ten Thousand Dollars ($10,000.00). If at any time the surplus of such sponsor shall be less than the surplus set out in this paragraph, such sponsor shall be considered impaired; and it shall be the duty of the secretary-treasurer, directors and other proper officers of such sponsor to report any such impairment of surplus to the commissioner of insurance of this state in writing within ten (10) days after such impairment occurs. When any such impairment is reported, or if the commissioner of insurance should otherwise gain knowledge of the fact that the surplus of any such sponsor has been impaired, the commissioner shall forthwith suspend the certificate of authority or license of such sponsor to do business in this state until such sponsor shall raise or increase its surplus to the amount equal to that required herein.

**SOURCES: Laws, 1983, ch. 474, § 12, eff from and after July 1, 1983.**

**Cross References** — Requirement for license for sponsors other than insurers, see § 83-49-7.

Investigations of applications for licenses, see § 83-49-9.

Revocation, suspension or refusal to renew license, see § 83-49-11.

Disposition of deposits placed with commissioner, see § 83-49-41.

Reserve requirements, see § 83-49-49.

## § 83-49-25. Annual report; contents.

Every sponsor of a prepaid legal services plan shall, annually, on or before the first day of March, file in the office of the commissioner the following items:

(a) A statement, verified by at least two (2) of its principal officers or trustees, showing the financial condition of the plan on December 31 then next preceding, which shall be in such form and shall contain such matters as the commissioner shall prescribe;

(b) A statistical summary listing the numbers and types of claims paid and the average dollar amount of each type of claim;

(c) A list of the groups currently subscribing to the plan;

(d) A statement of the name, organizational form and principal place of business of the plan, and the name, organizational form and principal place of business of the sponsor of the plan;

(e) Copies of all advertising or solicitation material which the plan is using; and

(f) Such other pertinent and relevant information as the commissioner may reasonably require for the proper administration of this chapter. Provided, that all information furnished under this subsection (f) shall be kept confidential by the commissioner and shall not be made public by the commissioner or any other person, without the prior written consent of the sponsor or insurer to which it pertains unless the commissioner, after giving the sponsor or insurer who would be affected thereby, notice and opportunity to be heard, determines that the interests of the subscribers, policyholders, or the public will be served by the publication thereof, in which event he may publish all or any part thereof in such manner as he may deem appropriate, except to the extent that it may be produced in any judicial or administrative proceeding and may be admissible in evidence therein.

**SOURCES: Laws, 1983, ch. 474, § 13, eff from and after July 1, 1983.**

## § 83-49-27. Retention of records; inspection and report; expenses.

(1) The commissioner shall require every sponsor of a prepaid legal services plan to retain at the address shown on its license the plan-related books, records, accounts and vouchers for a term of three (3) years beginning immediately after the completion of the transaction and kept in such manner that the commissioner or his authorized representatives may readily verify its annual statements and determine whether the plan and the sponsor are in compliance with the law.

(2) The commissioner, or his designee, shall at least every three (3) years visit each sponsor of a prepaid legal services plan and examine into such of its affairs as relate to the business of operating the plan. The commissioner shall have free access to all plan-related books, records, accounts and vouchers of the plan and may summon and examine under oath officers, trustees, agents and employees of the plan and any other persons regarding the affairs and condition of the plan. Provided, that no information, written or oral, need be supplied under this or any other subsection of this chapter in violation of the attorney-client privilege as it is construed by the courts of this state.

(3) Every sponsor of a plan being examined, its officers, employees and agents shall produce and make freely accessible to the commissioner the accounts, records, documents and files in its possession or control relating to the subject of the examination. Such officers, employees and agents shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(4)(a) The commissioner shall make a full written report of each examination made by him containing only facts ascertained from the accounts, records and documents examined and from the sworn testimony of witnesses.

(b) The commissioner shall furnish a copy of the proposed report to the sponsor of the plan examined not less than twenty (20) days prior to filing the report. If such plan so requests in writing within such twenty-day period, or such longer period as the commissioner may grant, the commissioner shall grant a hearing with respect to the report, and shall not so file the report until after the hearing and such modifications have been made therein as the commissioner may deem proper.

(c) The commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the plan examined from unwarranted injury.

(d) After the report has been filed, the commissioner may publish the report or the results thereof in one or more newspapers published in this state if he should deem it to be in the public interest.

(5) The sponsor of the plan so examined shall pay, at the direction of the commissioner, all the actual travel and living expenses of such examination. When the examination is made by an examiner who is not a regular employee of the department, the sponsor examined shall pay the proper charges for the

services of the examiner and his assistants in an amount approved by the commissioner. A consolidated account for the examination shall be filed by the examiner with the commissioner. No sponsor or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the Insurance Department, payment for such services and proper expenses shall be made by the sponsor examined to the commissioner, and such payment shall be deposited with the State Treasurer to the account of the Insurance Department.

**SOURCES: Laws, 1983, ch. 474, § 14; Laws, 1991, ch. 573, § 123, eff from and after July 1, 1991.**

**Cross References** — Requirement that state officials pay over funds received to state treasury, see § 7-9-21.

Filing of annual statements, see § 83-49-25.

## § 83-49-29. Hearings and proceedings to be in conformity with §§ 83-17-123 et seq.

Except as otherwise provided in this chapter, all hearings and proceedings held under this chapter shall be conducted in accordance with the provisions of Section 83-17-123 et seq. and the commissioner shall have all the powers granted to him therein.

**SOURCES: Laws, 1983, ch. 474, § 15, eff from and after July 1, 1983.**

**Editor's Note** — Section 83-17-123, referred to in the section, was repealed by Laws of 2001, ch. 510, § 34, effective from and after January 1, 2002.

**Cross References** — Hearings on denial of sponsor's license, see § 83-49-9.

Hearings on revocation, suspension or refusal to renew sponsor's or representative's license, see § 83-49-11.

Hearings on denial of license to act as agent or representative of sponsor, see § 83-49-47.

## § 83-49-31. Injunctive relief against plans in violation of chapter; appointment of receivers; enforcement of criminal laws.

If the commissioner finds that any prepaid legal services plan operator or its sponsor (a) has failed to comply with any provision of this chapter; (b) is fraudulently operated; (c) is in such condition as to render further plan operations hazardous to the public interest or the interest of subscribers; (d) is financially unable to meet its obligations and claims as they come due; or (e) has violated any other provision of law, he may apply to the Circuit Court of the First Judicial District of Hinds County, State of Mississippi, for an injunction. The court may forthwith issue a temporary injunction restraining the transaction of any business by the plan, and it may, after a full hearing, make the injunction permanent, and appoint one or more receivers to take the plan to settle its affairs, and distribute its funds to those entitled thereto, subject to such rules and orders as the court may prescribe. If it appears that a crime has been committed in connection with the sale, advertisement, administration or management of any prepaid legal services plan, the attorney general of the State of Mississippi may pursue the appropriate criminal action.

**SOURCES: Laws, 1983, ch. 474, § 16, eff from and after July 1, 1983.**

**Cross References** — First judicial district of Hinds County, see §§ 9-7-23, 9-7-25.

Conjunctions generally, see §§ 11-13-1 et seq.

## § 83-49-33. Venue provisions applicable to sponsors.

The venue provisions applicable to "insurers" under Title 83, Chapters 19 and 21, Mississippi Code of 1972, shall apply to sponsors as defined in this chapter.

**SOURCES: Laws, 1983, ch. 474, § 17, eff from and after July 1, 1983.**

**Cross References** — Domestic insurance companies, see §§ 83-19-1 et seq.

Foreign insurance companies, see §§ 83-21-1 et seq.

Venue for injunctive relief from violations of this chapter and appointment of receivers, see § 83-49-31.

## § 83-49-35. Rules and regulations.

The commissioner shall have full power and authority to promulgate and adopt rules and regulations necessary for the implementation of this chapter.

**SOURCES: Laws, 1983, ch. 474, § 18, eff from and after July 1, 1984.**

**Cross References** — Revocation, suspension or refusal to renew license for violation of rules and regulations of commissioner, see § 83-49-11.

## § 83-49-37. Insurers to be in conformity with this chapter and other laws.

All insurers licensed to transact life or casualty insurance in this state who are licensed to issue policies of prepaid legal services insurance in this state shall be required to meet all the requirements of this chapter, unless specifically excepted therefrom by this chapter. Provided, that nothing contained herein shall be deemed to relieve the obligations of an insurer licensed to transact life or casualty insurance in this state from complying with the requirements of the Mississippi Code of 1972 and any other applicable laws of this state.

**SOURCES: Laws, 1983, ch. 474, § 19; Laws, 1997, ch. 307, § 10, eff from and after July 1, 1997.**

## § 83-49-39. Investment of funds.

A sponsor shall invest the funds of a prepaid legal services plan only in such investments as are authorized by the laws of this state for the investment of assets of domestic casualty insurance companies and subject to the limitations thereon or in such investments as are authorized by the laws of this state for the investment of assets of corporations authorized to transact business in this state pursuant to the provisions of Title 83, Mississippi Code of 1972, as the case may be.

**SOURCES: Laws, 1983, ch. 474, § 20, eff from and after July 1, 1983.**

**Cross References** — Investment of funds by domestic insurance companies, see §§ 83-19-51 through 83-19-55.

Foreign insurance companies generally, see §§ 83-21-1 et seq.

Investment of assets of mutual insurance companies, see § 83-31-29.

## § 83-49-41. Disposition of deposits.

Any deposits of a sponsor of a prepaid legal services plan deposited with the commissioner pursuant to the provisions of this chapter shall be administered by the commissioner in accordance with the provisions of the Mississippi Code of 1972 as though deposited by a domestic casualty insurer authorized to transact insurance in this state or as deposited by a corporation authorized to transact business in this state pursuant to the provisions of Chapter 19, Title 83, Mississippi Code of 1972, as the case may be.

**SOURCES: Laws, 1983, ch. 474, § 21, eff from and after July 1, 1983.**

**Cross References** — Deposits required of certain sponsors, see § 83-49-23.

## § 83-49-43. When subscription contracts may first be issued.

(1) No subscription contracts for prepaid legal services may be sold or offered for sale in this state prior to July 1, 1983. Provided, that nothing contained herein shall be deemed to prohibit an insurer authorized to transact life or casualty insurance in this state from selling or offering for sale in this state before July 1, 1983, individually underwritten and individually issued policies of prepaid legal services insurance on policy forms which have been approved by the commissioner pursuant to the provisions of the Mississippi Code of 1972, and Section 83-49-17.

(2) The provisions of this section shall not apply to any subscription contracts negotiated and issued in accordance with the provisions of section 302C of the Labor Management Relations Act of 1947 (87 Stat. 314, 29 USCA Section 186(c)(8)).

**SOURCES: Laws, 1983, ch. 474, § 22, eff from and after July 1, 1983.**

## § 83-49-45. Tax imposed on premiums; collection and enforcement.

(1) In addition to any license fee or tax now or hereafter provided by law, which shall be paid when the company or sponsor enters or is admitted to do business in this state, there is hereby levied and imposed upon all insurance companies and sponsors an additional annual license or privilege tax of three percent (3%) of the gross amount of premium receipts received from, and on prepaid legal services insurance policies and subscription contracts as defined in this chapter, written in or covering risks located in this state. In determining said amount of premiums, there shall be deducted therefrom premiums received for reinsurance from companies authorized to do business in this state, cash dividends paid under policy contracts or subscription contracts in this state, and premiums returned to policyholders or subscribers and cancellation on accounts of policies or subscription contracts not taken. The term "premium" as used herein shall also include policy fees, membership fees and monthly subscription contract charges and all other fees collected by the companies or sponsors. No credit or deduction from gross premium receipts shall be allowed for any commission, fee or compensation paid to any agent, solicitor or representative.

(2) Every insurance company or sponsor liable for the tax under the provisions hereof shall, quarterly each year as designated by the state tax commission, make and file with the state tax commission a full and correct statement, under oath of its president, secretary or other duly authorized officer at its home or head office in this country, of the gross amount of its premium receipts during the reporting period, and shall, at the time of filing such report, pay to the tax commission the tax levied hereby upon the premium collections for said period, computed as provided in subsection (1) of this section.

Every insurance company or sponsor liable for the payment of tax hereunder shall file an annual reconciliation statement of taxes paid during the previous year. The annual reconciliation statement shall be in the form prescribed by the state tax commission and shall be filed with the state tax commission on or before the last day of February following the close of each calendar year.

The state tax commission shall have the authority to promulgate rules and regulations, not inconsistent with this article, as it may deem necessary to enforce its provisions.

(3) If any insurance company, foreign or domestic, or sponsor shall fail to pay the tax imposed by this chapter at the time required therein, such company or sponsor shall be liable for the full amount of such tax, plus a penalty of twenty percent (20%) of the amount thereof, together with interest at the rate of twelve percent (12%) per annum from the due date of such taxes until same shall be paid.

(4) All taxes for which any company or sponsor is liable under the provisions of this chapter, and all penalties and interest due thereon, shall be

collected and recovered by the state tax commission in the same manner provided by the law for the collection of sales taxes; and all administrative provisions of the Mississippi Sales Tax Law, including those which fix damages, penalties and interest for nonpayment of taxes, failure to file returns, and for other noncompliance with the provisions of said chapter, and all other requirements and duties imposed upon taxpayers, shall apply to all persons liable for taxes under the provisions of this chapter; and the state tax commission shall exercise all the power and authority to perform all the duties with respect to taxpayers under this section as are provided in the Mississippi Sales Tax Law, except that in cases that conflict with the provisions of this chapter, in which case the provisions of this chapter shall prevail.

**SOURCES: Laws, 1983, ch. 474, § 23, eff from and after July 1, 1983.**

**Editor's Note —** Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

**Cross References —** Department of Revenue generally, see §§ 27-3-1 et seq.

Administration and enforcement of Sales Tax Law generally, see §§ 27-65-1 et seq.

## § 83-49-47. Agent or representative of sponsor; license required; fee; investigation; denial; grounds for issuance.

(1) No person shall act as a representative of a sponsor or agent of a sponsor as defined in Section 83-17-1, Mississippi Code of 1972, without first having obtained a license from the commissioner to act as an agent or representative of a sponsor of prepaid legal services in this state.

(2) The annual license fee shall be Ten Dollars ($10.00). The fee for said license shall be paid to the commissioner on or before March 1 of each year.

(3) Before any licensee changes his address, he shall return his license to the commissioner, who shall endorse the license indicating the change.

(4) Each person to whom the license or the renewal thereof may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner shall have authority, at any time, to require the applicant to disclose fully the identity of all stockholders, partners, officers and employees, and he may, in his discretion, refuse to issue or renew a license in the name of any firm, partnership or corporation if he is not satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(5) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and shall issue a license if he finds the applicant is qualified in accordance with this chapter. If the commissioner does not so find, he shall, within ninety (90) days after he has received such application, so notify the applicant and, at the request of the applicant, give the applicant a full hearing.

(6) The commissioner shall issue or renew a license applied for when he is satisfied that the person to be licensed:

(a) Is competent and trustworthy and intends to act in good faith as an agent or representative of a sponsor of prepaid legal services plans in this state;

(b) Has a good business reputation and has had experience, training or education so as to be qualified to act as an agent or representative of a sponsor of prepaid legal services plans.

**SOURCES: Laws, 1983, ch. 474, § 24, eff from and after July 1, 1983.**

**Cross References —** Revocation, suspension or refusal to renew sponsor's or representative's license, see § 83-49-11.

## § 83-49-49. Reserve.

Any insurer or sponsor operating or writing a prepaid legal services plan in this state shall be required to set aside as a legal reserve to protect the holders of its policy or subscription contracts in this state the pro rata unearned portion of the premium paid for such contract, to be held until termination of such contracts.

**SOURCES: Laws, 1983, ch. 474, § 25, eff from and after July 1, 1983.**

**Cross References —** Capitalization requirements for sponsors other than insurers, see § 83-49-23.

## CHAPTER 51

## Dental Care Benefits

Sec.
83-51-1. Definitions.
83-51-3. Provisions prohibited in health insurance policies and employee benefit plans.
83-51-5. Disclosure requirements; payments to non-contracting providers.
83-51-7. Provisions contrary to this chapter to be void.
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83-51-11. Contracts between dentist and patient; authority of provider of health insurance policy or employee benefit plan.
83-51-13. Limitation of applicability of chapter.

Prohibitions Against Certain Provisions In Contracts Between Certain Health Care Entities and Dentists .................................... 83-51-31

### § 83-51-1. Definitions.

As used in this chapter, the following words have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Health insurance policy" means any individual, group, blanket or franchise insurance policy, insurance agreement or group hospital service contract which provides benefits for dental care expenses incurred as a result of an accident or sickness;

(b) "Employee benefit plan" means any plan, fund or program heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, dental care benefits in the event of accident or sickness;

(c) "Dental care services" means those general and usual services furnished to any person for the purpose of preventing, alleviating, curing or healing human dental illness or injury as defined in Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(d) "Dentist" means any person who furnishes dental care services and who is licensed as a dentist by the State of Mississippi.

**SOURCES: Laws, 1985, ch. 369, § 1, eff from and after July 1, 1985.**

#### ATTORNEY GENERAL OPINIONS

The Dental Care Benefits Law (Section 83-51-1 et seq.) is inapplicable to the Children's Health Insurance Program (CHIP), which is not under the jurisdiction of the Department of Insurance, but was, pursuant to Section 41-86-9, developed by the Children's Health Insurance Program Commission; thus, the School Employees Health Insurance Management Board (HIMB) is not prohibited from requiring that dentists meet certain minimum requirements in order to receive reimbursement for services rendered to children under CHIP, nor is HIMB prohibited from requiring that dentists participate in a provider network in order to receive reimbursement for services rendered to children under CHIP. Anderson and Dale, Dec. 6, 2002, A.G. Op. #02-0433.

## § 83-51-3. Provisions prohibited in health insurance policies and employee benefit plans.

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:

(a) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by such policy or plan, or interfere with such selection, provided the dentist selected is licensed to furnish such dental care services in this state;

(b) Deny any dentist the right to participate as a contracting provider for such policy or plan, provided the dentist is licensed to furnish the dental care services offered by such policy or plan;

(c) Authorize any person to regulate, interfere or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing or healing dental illness or injury, provided such dentist practices within the scope of his license; or

(d) Require that any dentist furnishing dental care services make or obtain dental x-rays or any other diagnostic aids for the purpose of preventing, alleviating, curing or healing dental illness or injury; provided, however, that nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan.

Nothing in this chapter shall prohibit the predetermination of benefits for dental care expenses prior to treatment by the attending dentist.

**SOURCES: Laws, 1985, ch. 369, § 2, eff from and after July 1, 1985.**

## § 83-51-5. Disclosure requirements; payments to non-contracting providers.

Any health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall, to the extent that it provides benefits for dental care expenses:

(a) Disclose, if applicable, that the benefit offered is limited to the least costly treatment;

(b) Define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary," "reasonable and customary," "usual, customary and reasonable," or fees or words of similar import, or it shall specify in dollars and cents the amount of the payment or reimbursement for dental care services to be provided. Payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount specified or which is greater than the fee charged by the providing dentist for the dental care services rendered.

**SOURCES: Laws, 1985, ch. 369, § 3, eff from and after July 1, 1985.**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (b). The word "reimbursment" was changed to "reimbursement." The Joint Committee ratified the correction at its December 3, 1996, meeting.

## § 83-51-7. Provisions contrary to this chapter to be void.

Any provision in a health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this chapter shall, to the extent of such conflict, be void.

**SOURCES: Laws, 1985, ch. 369, § 4, eff from and after July 1, 1985.**

## § 83-51-9. Benefits not mandated.

The provisions of this chapter do not mandate that any type of benefits for dental care expenses be provided by a health insurance policy or an employee benefit plan.

**SOURCES: Laws, 1985, ch. 369, § 5, eff from and after July 1, 1985.**

## § 83-51-11. Contracts between dentist and patient; authority of provider of health insurance policy or employee benefit plan.

Notwithstanding any other provision of this chapter:

(a) A dentist may contract directly with a patient for the furnishing of dental care services to such patient as may be otherwise authorized by law;

(b) Any person providing a health insurance policy or employee benefit plan, or an employer, or an employee organization may:

(i) Make available to its insureds, beneficiaries, participants, employees or members information relating to dental care services by distributing factually accurate information regarding dental care services, rates, fees, location and hours of service, provided such distribution is made upon the request of any dentist licensed by the state; or

(ii) Establish an administrative mechanism which facilitates payment for dental care services by insureds, beneficiaries, participants, employees or members to the dentist of their choice; or

(iii) Pay or reimburse, on a non-discriminatory basis, its insureds, beneficiaries, participants, employees or members for the cost of dental care services rendered by the dentist of their choice.

**SOURCES: Laws, 1985, ch. 369, § 6, eff from and after July 1, 1985.**

## § 83-51-13. Limitation of applicability of chapter.

The provisions of this chapter do not apply to Article 3, Chapter 41, Title 83, Mississippi Code of 1972, which provides for the organizing of nonprofit hospital, medical and surgical service corporations, and do not apply to the Nonprofit Dental Service Corporation Law or to employee benefit plans paid for completely by the employer covering the employee and his or her dependents.

**SOURCES: Laws, 1985, ch. 369, § 7, eff from and after July 1, 1985.**

**Editor's Note** — Article 3, Chapter 41, Title 83, referred to in this section was repealed by Laws of 1997, ch. 307, effective July 1, 1997.

**Cross References** — Nonprofit Dental Service Corporation Law, see §§ 83-43-1 et seq.

## PROHIBITIONS AGAINST CERTAIN PROVISIONS IN CONTRACTS BETWEEN CERTAIN HEALTH CARE ENTITIES AND DENTISTS

SEC.
83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement [Repealed effective July 1, 2012].

## § 83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement [Repealed effective July 1, 2012].

(1) No contract between a health care entity that offers a dental plan or plans and a dentist for the provision of services to subscribers may require that a dentist provide services to his subscribers at a fee set by the health care entity unless the services are covered services under the applicable subscriber agreement. For the purposes of this section, "covered services" means services that are reimbursable under the applicable subscriber agreement, notwithstanding any deductibles, waiting periods or frequency limitations that may apply. For the purposes of this section, "dental plan" means any policy of insurance that is issued by a health care entity that provides for coverage of dental services not in connection with a medical plan.

(2) The provisions of this section shall stand repealed from and after July 1, 2012.

**SOURCES: Laws, 2010, ch. 497, § 1, eff from and after July 1, 2010.**

# CHAPTER 53

## Credit Life and Credit Disability Insurance

Sec.
83-53-1. Legislative purpose; construction.
83-53-3. Scope of chapter; definitions.
83-53-5. Permissible forms of insurance.
83-53-7. Limitations on amount of insurance.
83-53-9. Term of insurance.
83-53-11. Reinsurance and retrocession agreements.
83-53-13. Requirement of individual policy or certificate of insurance; contents.
83-53-15. Requirement of commissioner's approval with respect to insurance matters; judicial review.
83-53-17. Premium rates; refunds; remission of premiums by agent; rules relative to insurer's certification of compliance with chapter.
83-53-19. Reporting and settlement of claims; maintenance of claim files.
83-53-21. Freedom of debtor to procure insurance from any authorized company.
83-53-23. Reasonable insurance rates; prohibition against additional charges.
83-53-25. Limitation upon compensation in connection with insurance contract.
83-53-27. Additional compensation payable to credit life/credit disability supervising general agent; functions and duties of supervising general agents.
83-53-29. Promulgation of rules and regulations; requirement of information.
83-53-31. Issuance of cease and desist order; penalties.
83-53-33. Hearing relative to cease and desist order; costs; service of process.
83-53-35. Order, after hearing, as to findings, conclusions, and decision.
83-53-37. Judicial review.
83-53-39. Effective dates of orders; stay of execution or enforcement.
83-53-41. Appeal from order which does not charge violation.
83-53-43. Penalty for violation of final order; civil action to recover penalty.
83-53-45. Time for hearing.
83-53-47. Relation to other laws.

## § 83-53-1. Legislative purpose; construction.

The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this chapter is intended to prohibit or discourage competition which is in the public interest. The provisions of this chapter shall be liberally construed.

**SOURCES: Laws, 1986, ch. 440, § 1, eff from and after May 1, 1986.**

**Cross References** — Creditor-placed insurance under the Mississippi Creditor-Placed Insurance Act, see §§ 83-54-1 et seq.

### JUDICIAL DECISIONS

**1. In general.**

Regulation adopted by Insurance Commissioner, requiring credit life insurers to substantiate loss ratio of 50% "at all ages (i.e., each age band)" before charging rates exceeding statutory rate, was inconsistent with statute allowing rate variance to be granted when loss ratio for particular class is at least 50%; accordingly, regulation was outside scope of Commissioner's power to promulgate. American Federated Life Ins. Co. v. Dale, 701 So. 2d 809 (Miss. 1997).

### RESEARCH REFERENCES

**ALR.** Failure of creditor, or creditor's assignee, to secure credit insurance as affecting rights or liabilities of debtor, upon debtor's loss. 88 A.L.R.3d 794.

Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-3. Scope of chapter; definitions.

(1) All credit life insurance and all credit disability insurance sold in connection with loans or other credit transactions, including lease payments and residuals, shall be subject to the provisions of this chapter, except:

(a) Such insurance sold in connection with a loan or other credit transaction of more than ten (10) years' duration;

(b) Such credit life insurance sold in connection with a loan or other credit transaction of an agricultural cooperative financial institution authorized to do business in this state by any act of the Congress of the United States or by the laws of the State of Mississippi; and

(c) Such insurance where its issuance is an isolated transaction on the part of the insurer not related to an agreement or a plan or regular course of conduct for insuring debtors of the creditor.

(2) For the purposes of this chapter:

(a) "Commissioner" means the Commissioner of Insurance of the State of Mississippi;

(b) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transactions, including lease payments and residual, exclusive of any such insurance procured at no expense to the debtor, and credit life insurance on agricultural credit transactions. Insurance shall be deemed procured at no expense to the debtor unless the cost of the credit transaction to the debtor varies depending on whether or not the insurance is procured;

(c) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(d) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, which lender, vendor or lessor is the beneficiary of any credit life insurance or credit disability insurance sold in connection with such credit transaction.

(e) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction; and

(f) "Indebtedness" means the total amount payable by the debtor to a creditor in connection with a loan or other credit transaction.

(g) "Insurer" means an insurance company licensed in the State of Mississippi to write credit life insurance and credit disability insurance.

(h) "Insurance premium" shall include that portion collected or payable which is compensation as set forth in Section 83-53-25.

**SOURCES: Laws, 1986, ch. 440, § 2, eff from and after May 1, 1986.**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (d) of subsection (2). The words "any such lender, vendor or lessor, which lendor" were changed to "any such lender, vendor or lessor, which lender." The Joint Committee ratified the correction at its May 20, 1998, meeting.

**Cross References** — Commissioner of Insurance generally, see § 83-1-3.

Provision that, for purposes of this chapter, the term "insurance premium" includes that portion collected or payable which is compensation as set forth in this section, see § 83-53-3.

### RESEARCH REFERENCES

**ALR.** Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 522.

**CJS.** 45 C.J.S., Insurance § 1254.

## § 83-53-5. Permissible forms of insurance.

Credit life insurance and credit disability insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the term plan;

(b) Individual policies of disability insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and

(d) Group policies of disability insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

**SOURCES: Laws, 1986, ch. 440, § 3, eff from and after May 1, 1986.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 183-206.

**CJS.** 44 C.J.S., Insurance §§ 384-406.

## § 83-53-7. Limitations on amount of insurance.

(1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness. In the case of revolving loan or revolving charge accounts, the insurance shall not at any time exceed the unpaid indebtedness.

Notwithstanding the provisions of the above paragraph, the amount of insurance on agricultural loan commitments may be equal to the amount of the loan commitment.

(2) The total amount of periodic indemnity payable by credit disability insurance, in the event of disability as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness, and the amount of each periodic indemnity shall not exceed the total amount repayable divided by the number of periodic installments.

**SOURCES: Laws, 1986, ch. 440, § 4, eff from and after May 1, 1986.**

### JUDICIAL DECISIONS

**1. Total of payments.**

It is not a violation of statute in Mississippi to calculate the amount of credit insurance on the total of payments; rather, by statute, this is permissible. Harrison v. Commercial Credit Corp., — F. Supp. 2d —, 2002 U.S. Dist. LEXIS 7959 (S.D. Miss. Mar. 28, 2002).

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance § 522.

**CJS.** 45 C.J.S., Insurance § 1254.

## § 83-53-9. Term of insurance.

The term of any credit life insurance or credit disability insurance shall commence on the date when the debtor becomes obligated to the creditor, or the date the debtor applies for such insurance, whichever is later, except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than ninety (90) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the debtor to be insurable, and in such event there shall be an approximate refund or adjustment on any charge to the debtor for insurance. The term of such insurance shall not extend more than thirty (30) days beyond the scheduled maturity date of the indebtedness, except when extended without additional cost to the debtor.

**SOURCES: Laws, 1986, ch. 440, § 5, eff from and after May 1, 1986.**

### RESEARCH REFERENCES

**ALR.** Initiation and termination of coverage under group credit life or disability insurance. 5 A.L.R.3d 962.

Effective date of group life insurance as to individual policies of employees. 66 A.L.R.3d 1175.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 262-281, 412, 413.

**CJS.** 44 C.J.S., Insurance §§ 409-412.

## § 83-53-11. Reinsurance and retrocession agreements.

An insurer licensed in the State of Mississippi may not enter into any reinsurance agreement or retrocession agreement, with another insurance company after May 1, 1986, whereby credit life or credit accident and health insurance on risks located within this state, would be ceded to an insurer which is not licensed to engage in the writing of such lines of insurance within the State of Mississippi, or which does not meet the statutory financial and other requirements for admission and licensing in this state. An insurer shall not enter into any such reinsurance or retrocession agreement with another insurance company which would by the terms and provisions thereof serve to, either directly or indirectly, circumvent this chapter or any other law of the State of Mississippi, or any regulation issued thereunder. The commissioner shall have the right to inspect, review and approve any reinsurance or retrocession agreement between insurance companies affecting any risks or insureds located in the State of Mississippi pertaining to credit life or credit disability insurance. Provided, however, any reinsurance or retrocession agreements between insurance companies in effect prior to May 1, 1986, shall be allowed to continue, but this chapter shall apply to any renewal, extension, endorsement or similar amendment of any such reinsurance or retrocession agreement.

**SOURCES: Laws, 1986, ch. 440, § 6, eff from and after May 1, 1986.**

### RESEARCH REFERENCES

**Am Jur.** 44A Am. Jur. 2d, Insurance §§ 1809-1825.

**CJS.** 46 C.J.S., Insurance §§ 1720-1748.

## § 83-53-13. Requirement of individual policy or certificate of insurance; contents.

(1) All credit life insurance and credit disability insurance subject to this chapter shall be evidenced by an individual policy or, in the case of group

insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life insurance or credit disability insurance or any combination thereof or both shall, in addition to other requirements of law, set forth the name of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and credit disability insurance, a description of the coverage, including the amount and term thereof, and any exceptions, limitations and restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, whenever the amount of insurance may exceed the unpaid indebtedness, that any excess shall be payable to a beneficiary, other than the creditor, named by the debtor, or his estate.

(3) Notwithstanding the provisions of subsection (2) of this section, a certificate issued where the indebtedness is a revolving loan or revolving charge account, may set forth the rate of premium or amount of payment.

**SOURCES: Laws, 1986, ch. 440, § 7, eff from and after May 1, 1986.**

### JUDICIAL DECISIONS

**1. In general.**

An agent had apparent authority to issue a credit life insurance policy in excess of the master policy limits, and therefore his actions in issuing such a policy were binding on the insurance company, where the insurance company furnished the agent with blank certificates of insurance bearing the insurance company logo, the agent regularly issued policies of credit life insurance through the insurance company using these forms, and the agent had previously issued policies in excess of the master policy limits on several occasions. Malta Life Ins. Co. v. Estate of Washington, 552 So. 2d 827 (Miss. 1989).

### RESEARCH REFERENCES

**ALR.** Binding effects of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds. 6 A.L.R.4th 835.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 183-206.

**CJS.** 44 C.J.S., Insurance §§ 384-406.

## § 83-53-15. Requirement of commissioner's approval with respect to insurance matters; judicial review.

All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state, and the schedules of premium rates pertaining thereto, shall be filed with the commissioner for his approval prior to use.

If after filing, the commissioner notifies the insurer that the form is disapproved, it is unlawful for the insurer to issue or use the form. In the notice the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within thirty (30) days after receipt of request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider shall be issued or used unless and until the commissioner shall give his prior written approval thereto.

Any insurer or other party affected by any order or final determination of the commissioner under the provisions of this section may obtain judicial review thereof by filing in the Circuit Court of Hinds County within thirty (30) days from the date thereof a written petition or complaint praying that said order or final determination be modified or reversed. A copy of such petition or complaint shall be forthwith served upon the commissioner, and the commissioner shall file a transcript of the entire record of the proceedings with said court, which shall then have jurisdiction of the proceedings and questions determined therein. Said court shall have the power to make or enter a judgment modifying, affirming or reversing the order or final determination of the commissioner in whole or in part.

A premium rate or schedule of premium rates shall be deemed reasonable for all purposes under this chapter and shall be deemed approved by the commissioner upon filing with the commissioner as required by this section if the premium rate or schedule of premium rates meets the requirements for being considered reasonable under Section 83-53-23. However, a different premium rate or schedule of premium rates shall be deemed reasonable upon the filing thereof with the commissioner as required by this section if it produces, or reasonably may be expected to result in claims incurred in excess of fifty percent (50%) of earned premiums.

**SOURCES: Laws, 1986, ch. 440, § 8, eff from and after May 1, 1986.**

### RESEARCH REFERENCES

**ALR.** Validity and construction of statutes relating to style or prominence with which provisions must be printed in insurance policy. 36 A.L.R.3d 464.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-17. Premium rates; refunds; remission of premiums by agent; rules relative to insurer's certification of compliance with chapter.

(1) Any insurer with the prior approval of the commissioner may revise its schedules of premium rates from time to time and shall file the revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as previously approved by the commissioner.

(2) Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly by the insurer to the person entitled thereto;

provided, however, that no refund of less than Two Dollars ($2.00) need be made. The formula to be used in computing the premium refund shall be the "sum of the digits" formula with respect to decreasing term credit life insurance and credit disability insurance, and the "pro rata" formula with respect to level term credit life insurance. Upon the payment of a death benefit under the credit life insurance coverage, the entire premium shall be considered earned and no refund shall be due. The insurer shall pay or cause to be paid to the debtor any refund due pursuant to this subsection within thirty (30) days of the accrual of such refund.

(3) The amount required of a debtor for any credit life or credit disability insurance shall not exceed the premium rate allowed to the insurer computed at the time the cost to the debtor is determined. All premiums payable to the insurer less any compensation to the agent or supervising general agent shall be remitted by the agent or supervising general agent to the insurer within sixty (60) days of collection.

(4) The commissioner may promulgate rules whereby an insurer may certify that the policy forms and other documents required to be approved by the commissioner prior to use are in compliance with this chapter.

**SOURCES: Laws, 1986, ch. 440, § 9, eff from and after May 1, 1986.**

## JUDICIAL DECISIONS

1. Unearned credit life premiums.
2. Notice of claim.

**1. Unearned credit life premiums.**

The record suggested that defendants, a lender and an affiliated insurer, had complied with the statutory and regulatory requisites in calculating refunds of unearned premiums for property insurance under the Rule of 78ths. Smith v. Tower Loan of Miss., Inc., 216 F.R.D. 338 (S.D. Miss. 2003).

The statute requires an insurer, but not a creditor, to make a prompt refund of unearned credit life premiums. No Mississippi law imposes a duty on a lender to refund unearned credit life premiums upon early termination of an installment contract. Mic Life Ins. Co. v. Hicks, — So. 2d —, 2000 Miss. App. LEXIS 299 (Miss. Ct. App. June 23, 2000), affirmed in part by, reversed in part by, remanded by 2001 Miss. LEXIS 296 (Miss. Oct. 31, 2001).

**2. Notice of claim.**

Credit life insurance premium added to the principal of an installment contract for the purchase of a truck resulted in the insurer holding unearned premiums after the loan was satisfied, but § 83-53-17 does not contain a notice requirement, so directed verdict for plaintiff, who was not notified of her right to a refund, could not stand. MIC Life Ins. Co. v. Hicks, 825 So. 2d 616 (Miss. 2002).

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 40-42.

**CJS.** 44 C.J.S., Insurance §§ 81-124.

## § 83-53-19. Reporting and settlement of claims; maintenance of claim files.

All claims shall be promptly reported by the debtor, his agent or estate to the insurer or its designated claims representative, who shall maintain adequate claim files. All claims shall be settled in accordance with the terms of the insurance contract by the insurer who shall be the sole party liable to the debtor for the payment of claims or refunds.

**SOURCES: Laws, 1986, ch. 440, § 10, eff from and after May 1, 1986.**

### RESEARCH REFERENCES

**ALR.** Validity, construction, and effect of provisions, in insurance policies allowing disability or accident benefits, which require insured to submit to physical examination. 5 A.L.R.3d 929.

Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts. 47 A.L.R.3d 314.

What conditions constitute "disease" within terms of life, accident, disability, or hospitalization insurance policy. 61 A.L.R.3d 822.

Libel and Slander: privileged nature of communications between insurer and insured. 85 A.L.R.3d 1161.

Doctrine of unconscionability as applied to insurance contracts. 86 A.L.R.3d 862.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith failure to pay, or delay in paying, insured's claim. 33 A.L.R.4th 579.

Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

**Am Jur.** 44 Am. Jur. 2d, Insurance §§ 1315, 1316, 1318 et seq.

**CJS.** 45 C.J.S., Insurance §§ 1417 et seq.

## § 83-53-21. Freedom of debtor to procure insurance from any authorized company.

When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor shall be free to procure the required insurance from any insurance company authorized to transact credit life insurance or credit disability insurance business in this state.

**SOURCES: Laws, 1986, ch. 440, § 11, eff from and after May 6, 1986.**

## § 83-53-23. Reasonable insurance rates; prohibition against additional charges.

(1) Credit life insurance rates filed with the commissioner shall be considered reasonable:

(a) If the single premium rate for single life decreasing term credit life insurance does not exceed Eighty Cents (80¢) per annum per One Hundred Dollars ($100.00) of initial insured indebtedness;

(b) If the single premium rate for single life level term credit life insurance does not exceed a single premium rate of One Dollar and Sixty

Cents ($1.60) per annum per One Hundred Dollars ($100.00) of insured indebtedness;

(c) If the monthly premium rate on single life credit life insurance on outstanding balances does not exceed a monthly premium of One Dollar and Thirty-three Cents ($1.33) per One Thousand Dollars ($1,000.00) of outstanding indebtedness;

(d) If the single premium rate for joint life decreasing term credit life insurance does not exceed One Dollar and Thirty-nine Cents ($1.39) per annum per One Hundred Dollars ($100.00) of initial insured indebtedness;

(e) If the single premium rate for joint life level term credit life insurance does not exceed Two Dollars and Eighty ($2.80) per annum per One Hundred Dollars ($100.00) of insured indebtedness;

(f) If a monthly premium rate on joint life credit life insurance on outstanding balances does not exceed a monthly premium of Two Dollars and Thirty-four Cents ($2.34) per One Thousand Dollars ($1,000.00) of outstanding indebtedness;

(g) If the amount is a minimum premium not exceeding Two Dollars ($2.00).

(2) The foregoing life insurance rates are considered reasonable in relation to the benefits only if:

(a) The credit life insurance coverage must contain a suicide exclusion provision wherein no benefit shall be paid in case of suicide within the first twelve (12) months after the effective date of the coverage.

(b) Coverage is provided or offered to all debtors regardless of age, or to all debtors not older than the applicable age limit, which shall not be less than the attained age of sixty-five (65) years, if the limit applies to the age when the insurance attaches, or not less than attained the age of sixty-six (66) years if the limit applies to the age on the scheduled maturity date of the debt. Such aforementioned requirements provided by this subsection shall not prevent the usage of equitable underwriting standards to determine the eligibility of individual debtors as to a part or all of the coverage provided by the credit life insurance contract. Age and term limits, wherein the amount of insurance provided or offered varies by age, if used, must be clearly shown on the individual policies or group certificates.

(3) The following credit disability insurance premium rates filed with the commissioner shall be considered reasonable in relation to the benefits if the single premium rate for credit disability insurance does not exceed the premium rates shown in the following schedule per One Hundred Dollars ($100.00) of initial insured indebtedness.

| NO. OF MONTHS IN WHICH INDEBTEDNESS IS PAYABLE | NONRETROACTIVE BENEFITS |  | RETROACTIVE BENEFITS |  |
|---|---|---|---|---|
|  | 14-DAY NONRETROACTIVE | 30-DAY NONRETROACTIVE | 14-DAY RETROACTIVE | 30-DAY RETROACTIVE |
| 1-12 | 2.50 | 2.10 | 3.00 | 2.85 |
| 13-24 | 3.30 | 2.90 | 3.80 | 3.65 |
| 25-36 | 4.10 | 3.70 | 4.60 | 4.45 |

| NO. OF MONTHS IN WHICH INDEBTEDNESS IS PAYABLE | NONRETROACTIVE BENEFITS | | RETROACTIVE BENEFITS | |
|---|---|---|---|---|
| | 14-DAY NONRETROACTIVE | 30-DAY NONRETROACTIVE | 14-DAY RETROACTIVE | 30-DAY RETROACTIVE |
| 37-48 | 4.90 | 4.50 | 5.40 | 5.25 |
| 49-60 | 5.70 | 5.30 | 6.20 | 6.05 |
| 61-72 | 6.10 | 5.70 | 6.60 | 6.45 |
| 73-84 | 6.50 | 6.10 | 7.00 | 6.85 |
| 85-96 | 6.90 | 6.50 | 7.40 | 7.25 |
| 97-108 | 7.30 | 6.90 | 7.80 | 7.65 |
| 109-120 | 7.70 | 7.30 | 8.20 | 8.05 |

Premiums payable other than on a single premium basis or for benefits on a basis different than illustrated above shall be actuarially consistent with the above rates.

(4) The foregoing disability rates are considered to produce reasonable benefits in relation to premiums only if:

(a) Coverage may be provided or offered to all debtors, who are gainfully employed on the effective date of insurance and who are not older than the applicable age limit, which shall not be less than the attained age of sixty-five (65) years, if the limit applies to the age when the insurance attaches, or not less than the attained age of sixty-six (66) years if the limit applies to the age on the scheduled maturity date of the debt. Such aforementioned requirements provided by this subsection shall not prevent the usage of equitable underwriting standards to determine the eligibility of individual debtors as to a part or all of the coverage provided by the disability insurance contract. Age and term limits, wherein the amount of insurance or term provided or offered varies by age, if used, must be clearly shown on the individual policies or group certificates;

(b) Coverage does not contain any exclusions except disabilities resulting from intentional self-inflicted injury, pregnancy, foreign residence, flights in nonscheduled aircraft and preexisting illness, disease or physical condition for which the debtor either: (i) knew the existence of such illness, disease or condition on the effective date, or (ii) received medical advice, consultation or treatment during the twelve-month period immediately preceding the effective date of the debtor's coverage.

(5) An insurer may receive approval of a different premium rate or schedule of premium rates to be used in connection with a particular policy form, or any type of coverage other than described herein, or a particular class or classes of risk of the debtors of a creditor, if the insurer demonstrates to the satisfaction of the commissioner that the mortality or morbidity experience which may reasonably be anticipated will develop a loss ratio in excess of fifty percent (50%).

(6) No certificate fee, policy issue charge, or any other charge other than the premium herein shall be made.

**SOURCES: Laws, 1986, ch. 440, § 12, eff from and after July 1, 1987.**

**Cross References** — Provision that premium rates shall be deemed approved by the commissioner upon filing if they meet the reasonableness requirements of this section, see § 83-53-15.

## JUDICIAL DECISIONS

**1. In general.**

Defendant lender was required to and did conduct its business pursuant to applicable statutes and regulations and, accordingly, was protected by law when it complied with these statutes and regulations; the borrowers affirmatively represented the value of the personal property to the lender in their promissory notes and security agreements so their allegations of excessive rates, or challenges of the "rates and terms" of the governmentally-approved insurance contracts, were barred by the filed rate doctrine. Smith v. Tower Loan of Miss., Inc., 216 F.R.D. 338 (S.D. Miss. 2003).

Though a credit disability insurer had an arguable basis for denying the insured's claim, since his disabling condition had been preexisting, as the jury could have concluded that the insurer acted with gross negligence or reckless disregard for the insured's rights, the trial court erred by granting the insurer judgment notwithstanding the verdict on a punitive damages award. Stewart v. Gulf Guar. Life Ins. Co., 846 So. 2d 192 (Miss. 2002).

Regulation adopted by Insurance Commissioner, requiring credit life insurers to substantiate loss ratio of 50% "at all ages (i.e., each age band)" before charging rates exceeding statutory rate, was inconsistent with statute allowing rate variance to be granted when loss ratio for particular class is at least 50%; accordingly, regulation was outside scope of Commissioner's power to promulgate. American Federated Life Ins. Co. v. Dale, 701 So. 2d 809 (Miss. 1997).

## RESEARCH REFERENCES

**ALR.** What constitutes "serious illness," "serious disease," or equivalent language used in insurance application. 28 A.L.R.3d 1255.

Time when period provided for in suicide clause of life or accident policy begins to run. 37 A.L.R.3d 933.

**Am Jur.** 44 Am. Jur. 2d, Insurance §§ 819-931.

**CJS.** 44 C.J.S., Insurance §§ 545-615.

## § 83-53-25. Limitation upon compensation in connection with insurance contract.

(1) No one shall pay, accrue, credit or otherwise allow, either directly or indirectly, any compensation to any creditor, person, partnership, corporation, association or other entity in connection with any policy, certificate or other contract of credit life insurance or credit disability insurance which exceeds forty-five percent (45%) of the premium rates approved for such policy, certificate or contract.

(2) "Compensation," as used herein, shall include, but not be limited to, all of the following:

(a) Commission, fees and expense allowances;

(b) The fair market value of all equipment, calculators, goods and services;

(c) The fair market value of benefits such as travel, vacations or other rewards of any kind; and

(d) All other accruals, payments and other compensation or expenditures in any form whatsoever.

(3) "Compensation" shall not include:

(a) Bona fide corporate dividends paid or accrued by an insurance company to a stockholder;

(b) Bona fide compensation paid to or reimbursement of expenses incurred by a director, officer or employee of an insurance company for the performance of the corporate duties of any such director, officer or employee;

(c) Experience refunds paid, allocated or accrued by an insurer pursuant to a written experience refund agreement which are paid only with respect to earned premiums produced by or attributable to the creditor or licensed agent designated to receive such experience refund; provided, however, that:

(i) All such experience refund agreements shall be on a form approved in writing by the commissioner;

(ii) All such experience refunds shall be calculated using only accounting methods approved by the commissioner;

(iii) All such experience refund calculations shall be made in accordance with the requirements of a form prescribed by the commissioner which form shall provide, among other things, for the deduction of claims incurred, premium taxes incurred, compensation paid (as defined herein) and expenses incurred during the preceding calendar year, all of which shall be determined in a manner acceptable to the commissioner; and

(iv) All such experience refunds shall be paid annually within thirty (30) days following the filing of the insurer's annual statement with the Department of Insurance;

(d) Corporate allocations or dividends paid, allocated or accrued by an insurer or insurance holding company from any part of the assets, income, earnings, profits or losses of any corporation, insurer or other legal entity with respect to any class or series of stock, or other equity interest, in the insurer or insurance holding company, including payments for the redemption or purchase by the issuer of such shares or other equity interest.

(4) The commissioner is hereby vested with full authority as provided by Section 83-53-29 to regulate, reduce and/or adjust experience refunds or corporate allocations in accordance with the provisions of paragraphs (c) and (d) of subsection (3) of this section.

**SOURCES: Laws, 1986, ch. 440, § 13; Laws, 1989, ch. 492, § 1, eff from and after July 1, 1989.**

**Cross References —** Additional compensation payable to credit life/credit disability supervising general agent, see § 83-53-27.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 171-182.

**CJS.** 44 C.J.S., Insurance §§ 198-253.

## § 83-53-27. Additional compensation payable to credit life/credit disability supervising general agent; functions and duties of supervising general agents.

(1) Notwithstanding any provision in Section 83-53-25 to the contrary, an insurer may pay, in addition to the compensation authorized by Section 83-53-25, an overriding commission to a credit life/credit disability supervising general agent. A supervising general agent shall be responsible for and supervise soliciting agents and no soliciting agent under the supervision of the supervising general agent may be either directly or indirectly an employee of a supervising general agent. Furthermore, no supervising general agent shall have any monetary interest in the creditor with whom the soliciting agent is affiliated for the writing of such insurance in any way or exercise any control over such business operation either directly or indirectly. A supervising general agent is defined as an individual or entity which performs the following documented functions:

(a) Provides administrative services for insurance companies in the hiring, training and supervision of all agents under the supervising general agent's authority;

(b) Provides underwriting services on behalf of the insurance company;

(c) Audits reports submitted by the soliciting agent;

(d) Requires compliance of all statutory responsibilities of soliciting agents under the supervising general agent's authority. Any supervising general agent who has knowledge of statutory violations by soliciting agents under such agent's supervision or responsibility may be subject to disciplinary action by the Insurance Department for the activities of that soliciting agent or agency.

(2) Documentation of the above responsibilities will include the following and must be retained by the supervising general agent for three (3) years:

(a) Written records certifying compliance of all hiring, training and monthly reports verifying continuous supervision of the soliciting agents' activities;

(b) Complete records certifying underwriting review of policies and group contracts.

(3) Supervising general agents may not receive directly or indirectly any soliciting agents' commissions nor pay any portion of such overriding commission to any creditor or other agent.

**SOURCES: Laws, 1986, ch. 440, § 14; Laws, 1989, ch. 492, § 2, eff from and after July 1, 1989.**

RESEARCH REFERENCES

**ALR.** Insurance agent's right to commissions on renewal premiums. 36 A.L.R.3d 958.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 171-182.

**CJS.** 44 C.J.S., Insurance §§ 198-253.

## § 83-53-29. Promulgation of rules and regulations; requirement of information.

The commissioner may, after notice and hearing, issue any rules and regulations that he deems necessary to effectuate the purposes of this chapter or to eliminate devices or plans designed to avoid or render ineffective the provisions of this chapter. The commissioner may require such information as is reasonably necessary for the enforcement of this chapter. All rules and regulations adopted and promulgated pursuant to this chapter shall be subject to the Mississippi Administrative Procedures Law.

**SOURCES: Laws, 1986, ch. 440, § 15, eff from and after May 6, 1986.**

**Cross References** — Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

Authority of commissioner to regulate experience refunds or corporate allocations, see § 83-53-25.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-31. Issuance of cease and desist order; penalties.

Whenever there has been a violation of this chapter or any rule or regulation issued pursuant thereto, the commissioner shall issue and serve upon the insurer, agent or other person charged with such violation an order requiring such person to cease and desist from violating this chapter or any rule or regulation issued pursuant thereto.

In addition, the commissioner, in the cease and desist order, may impose upon such person a fine not to exceed One Thousand Dollars ($1,000.00) for each violation and may revoke, suspend or decline to renew any license of such person to sell or issue insurance.

**SOURCES: Laws, 1986, ch. 440, § 16, eff from and after May 1, 1986.**

**Cross References** — Hearings with respect to cease and desist orders issued under this section, see § 83-53-33.

When orders of the commissioner become effective, see § 83-53-39.

### RESEARCH REFERENCES

**ALR.** Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-33. Hearing relative to cease and desist order; costs; service of process.

Any person affected by a cease and desist order issued under Section 83-53-31 may, within thirty (30) days after being served with such cease and desist order, petition the commissioner for a hearing to consider the alleged violation of this chapter or any rule or regulation issued pursuant thereto. The commissioner shall set the time and place of such hearing, which shall not be less than ten (10) days nor more than thirty (30) days after the date the petition is received by the commissioner.

At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why the order of the commissioner requiring such person to cease and desist from the violation or violations complained of should not be made final.

Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

Nothing contained herein shall require the observance at any such hearing of formal rules of pleadings or evidence.

The commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence or other documents which he deems relevant to the inquiry. The commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceeding had at such hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the Circuit Court of Hinds County, on application of the commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

The commissioner by regulation shall provide for the assessment of, costs for stenographic records, process and other related expenses pertaining to proceedings pursuant to this section, and may require a deposit or other security therefor.

Statements of charges, notices, orders and other processes of the commissioner may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such statement, notice, order or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order or other process, setting forth the manner of such service, shall be proof of the same; and the return postcard receipt for such statement, notice, order or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

**SOURCES: Laws, 1986, ch. 440, § 17, eff from and after May 6, 1986.**

**Cross References** — When orders of the commissioner become effective, see § 83-53-39.

Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-35. Order, after hearing, as to findings, conclusions, and decision.

After such hearing the commissioner shall issue and cause to be served upon the person charged with the violation and any petitioner or intervenor an order setting forth the commissioner's findings, conclusions and decision.

**SOURCES: Laws, 1986, ch. 440, § 18, eff from and after May 6, 1986.**

**Cross References** — Judicial review of an order issued under this section, see § 83-53-37.

When orders of the commissioner become effective, see § 83-53-39.

Appeal from an order under this section which does not charge a violation, see § 83-53-41.

Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-37. Judicial review.

Any person affected by an order of the commissioner under Section 83-53-35 may obtain a review of such order by filing in the Circuit Court of Hinds County, within thirty (30) days from the date of the service of such order, a complaint praying that the order of the commissioner be modified or set aside. A copy of such petition or complaint shall be forthwith served upon the commissioner, and thereupon the commissioner forthwith shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the findings and order of the commissioner. Upon such filing of the petition and transcript, such court shall have jurisdiction of the proceedings and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in such transcript a judgment modifying, affirming or reversing the order of the commissioner, in whole or in part. Any party, including the commissioner, aggrieved by a final decision of said circuit court, may appeal to the Supreme Court in the manner provided by law.

**SOURCES: Laws, 1986, ch. 440, § 19, eff from and after May 1, 1986.**

**Cross References —** Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

**RESEARCH REFERENCES**

**ALR.** Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-39. Effective dates of orders; stay of execution or enforcement.

A cease and desist order issued by the commissioner under Section 83-53-31 shall become final upon the completion of the time allowed for filing a petition with the commissioner for a hearing if no such petition has been duly filed within such time. If a petition for a hearing is filed within such time pursuant to Section 83-53-33, the order of the commissioner shall not take effect and be in force until the issuance of an order pursuant to Section 83-53-35. An order issued pursuant to Section 83-53-35 shall take effect and be in force upon issuance or at such time as may be stated in such order. The commissioner, in his discretion, or the circuit court, upon appeal, may stay the execution or enforcement of any such order.

**SOURCES: Laws, 1986, ch. 440, § 20, eff from and after May 6, 1986.**

**Cross References —** Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

**RESEARCH REFERENCES**

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-41. Appeal from order which does not charge violation.

If the order of the commissioner under Section 83-53-35 does not charge a violation of this chapter or any rule or regulation pursuant thereto, then any petitioner or intervenor in the proceedings may, within thirty (30) days after the service of such report, file a petition or complaint in the Circuit Court of Hinds County for a review of such order. Upon such review, the court shall have the authority to issue appropriate orders and decrees in connection therewith, including orders enjoining and restraining the continuance of any act which it finds, notwithstanding such order of the commissioner, constitutes a violation of this chapter or any rule or regulation issued pursuant thereto.

**SOURCES: Laws, 1986, ch. 440, § 21, eff from and after May 1, 1986.**

**Cross References —** Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-43. Penalty for violation of final order; civil action to recover penalty.

Any person who violates an order of the commissioner, after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Mississippi a sum to be determined by the commissioner not to exceed Five Thousand Dollars ($5,000.00) for each violation, which if not paid may be recovered in a civil action instituted in the name of the commissioner in the circuit court in the county of the residence of such person who is a resident of the state. In the case of a nonresident, the action shall be brought in the Circuit Court of Hinds County.

**SOURCES: Laws, 1986, ch. 440, § 22, eff from and after May 6, 1986.**

**Cross References —** Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-45. Time for hearing.

Whenever any insurer, agent or other interested party petitions the commissioner for a hearing to consider any alleged violation of this chapter or any rule or regulation issued pursuant thereto, the commissioner shall hold a hearing within thirty (30) days after the petition is filed with the commissioner and proceed as provided in Sections 83-53-33 through 83-53-43.

**SOURCES: Laws, 1986, ch. 440, § 23, eff from and after May 6, 1986.**

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 23-65.

**CJS.** 44 C.J.S., Insurance §§ 76-143.

## § 83-53-47. Relation to other laws.

Nothing in this chapter shall be construed to relieve any person from compliance with any other applicable law of this state.

**SOURCES: Laws, 1986, ch. 440, § 24, eff from and after May 6, 1986.**

# CHAPTER 54

## Mississippi Creditor-Placed Insurance Act

Sec.
83-54-1. Purpose of chapter.
83-54-3. Application and construction of chapter.
83-54-5. Definitions.
83-54-7. Effective date and termination date of coverage.
83-54-9. Insurance premiums.
83-54-11. Exclusions from coverage.
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83-54-15. Policy forms, certificates of insurance, and schedules of premium rates to be filed with Commissioner of Insurance; disapproval of forms or schedules; schedules not to be excessive, inadequate, or unfairly discriminatory; withdrawal of approval of approved forms or schedules; approved forms and schedules deemed to be in compliance with laws of the state.
83-54-17. Insurer to refund unearned premiums within 60 days after termination of coverage; statement of refund provided to debtor.
83-54-19. Payment by insurer in the event of loss.
83-54-21. Prerequisites for creditor to insure collateral; right of debtor to insure collateral.
83-54-23. Entire amount of premium due shall be remitted to insurer in accordance with insurer's requirements; creditor prohibited from retaining unearned premiums upon cancellation without crediting debtor's account; rebates to creditor prohibited.
83-54-25. Creditor to make adequate disclosure to debtor of insurance requirement; "adequate disclosure" defined; when creditor may impose charges; "reasonable efforts" to notify debtor; form of notice; evidence of insurance coverage; creditor not required to insure collateral.
83-54-27. Commissioner of Insurance authorized to conduct investigations of insurers and producers, to deny, suspend, or revoke certificates of authority or producer's licenses, and to impose civil penalties; judicial review of commissioner's orders.
83-54-29. Rules and regulations.
83-54-31. Severability.

### § 83-54-1. Purpose of chapter.

The purposes of this chapter are to:

(a) Promote the public welfare by regulating creditor-placed insurance;

(b) Create a legal framework within which creditor-placed insurance may be written in this state;

(c) Help maintain the separation between creditors and insurers; and

(d) Minimize the possibilities of unfair competitive practices in the sale of creditor-placed insurance.

**SOURCES: Laws, 2001, ch. 307, § 1, eff from and after July 1, 2001.**

**Cross References —** Credit life and credit disability insurance, see §§ 83-53-1 et seq.

## § 83-54-3. Application and construction of chapter.

(1) This chapter applies to an insurer or producer transacting creditor-placed insurance as defined in this chapter.

(2) All creditor-placed insurance written in connection with credit transactions for personal, family or household purposes is subject to the provisions of this chapter, except:

(a) Transactions involving extensions of credit primarily for business or commercial purposes;

(b) Insurance on collateralized real property; provided, however, that creditor-placed insurance written for mobile homes or manufactured housing shall be subject to the provisions of this chapter;

(c) Insurance offered by the creditor and elected by the debtor at the debtor's option;

(d) Insurance for which no specific charge is made to the debtor or the debtor's account; or

(e) Blanket insurance, whether paid for by the debtor or the creditor.

(3) Nothing in this chapter shall be construed to create or imply a private cause of action for violation of this chapter, and the commissioner shall have authority to bring administrative or judicial proceedings to enforce this chapter.

**SOURCES: Laws, 2001, ch. 307, § 2, eff from and after July 1, 2001.**

## § 83-54-5. Definitions.

As used in this chapter, unless the context otherwise requires:

(a) "Actual cash value (ACV)" means the cost of replacing damaged or destroyed property with comparable new property, minus depreciation and obsolescence.

(b) "Blanket insurance" means insurance that provides coverage on collateral as defined in a policy issued to a creditor, without specifically listing the collateral covered.

(c) "Collateral" means personal property that is pledged as security for the satisfaction of a debt.

(d) "Credit agreement" means the written document that sets forth the terms of the credit transaction and includes the security agreement.

(e) "Credit transaction" means a transaction by the terms of which the repayment of money loaned or credit commitment made, or payment of goods, services or properties sold or leased, is to be made at a future date or dates.

(f) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of a lender, vendor or lessor.

(g) "Creditor-placed insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized personal property as a result of fire, theft, collision or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral covered by limited dual interest insurance. It is purchased according to the terms of the credit agreement as a result of the debtor's failure to provide required physical damage insurance, with the cost of the coverage being charged to the debtor. It shall be either single interest insurance or limited dual interest insurance.

(h) "Debtor" means the borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(i) "Insurance tracking" means monitoring evidence of insurance on collateralized credit transactions to determine whether insurance required by the credit agreement has lapsed, and communicating with debtors concerning the status of insurance coverage.

(j) "Insurer" means an insurance company, association or exchange authorized to issue insurance policies in the State of Mississippi.

(k) "Lapse" means that the insurance coverage required by the credit agreement is not in force.

(*l*) "Limited dual interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing the debtor's credit transaction. This insurance waives the three (3) conditions for loss payment under single interest insurance and extends coverage on the collateral while in the possession of the debtor.

(m) "Loss ratio" means the ratio of incurred losses to earned premium.

(n) "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned charges.

(o) "Producer" means a person who receives a commission for insurance placed or written or who, on behalf of an insurer or creditor, solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance to which this chapter applies, except a regular salaried officer, employee or other representative of an insurer who devotes substantially all working time to activities other than those specified here and who receives no compensation that is directly dependent on the amount of insurance business written, and except a regular salaried officer or employee of a creditor who receives no compensation that is directly dependent on the amount of insurance effected or procured.

(p) "Single interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing a debtor's credit transaction. Three (3) conditions must be met for payment of loss under the policy:

(i) The debtor has defaulted in payment;

(ii) The creditor has legally repossessed the collateral, unless collateral has been stolen from the debtor; and

(iii) The creditor has suffered an impairment of interest.

(q) "Commissioner" means the Commissioner of Insurance.

**SOURCES: Laws, 2001, ch. 307, § 3, eff from and after July 1, 2001.**

## § 83-54-7. Effective date and termination date of coverage.

(1) Creditor-placed insurance shall become effective on the latest of the following dates:

(a) The date of the credit transaction;

(b) The date prior coverage, including prior creditor-placed insurance coverage lapsed;

(c) One (1) year before the date on which the related insurance charge is made to the debtor's account; or

(d) A later date provided for in the agreement between the creditor and insurer.

(2) Creditor-placed insurance shall terminate on the earliest of the following dates:

(a) The date other acceptable insurance becomes effective, subject to the debtor providing acceptable evidence of the other insurance to the creditor;

(b) The date the collateralized personal property is repossessed, unless the property is returned to the debtor within ten (10) days of the repossession. The creditor-placed insurance may be kept in force, but the lender must pay the premium that is earned after repossession;

(c) The date the collateralized personal property is determined by the insurer to be a total loss;

(d) The date the debt is completely extinguished; or

(e) An earlier date specified in the individual policy or certificate of insurance.

(3) An insurance charge shall not be made to a debtor for a term longer than the scheduled term of the creditor-placed insurance when it becomes effective, nor may an insurance charge be made to the debtor for creditor-placed insurance before the effective date of the insurance.

(4) If a charge is made to a debtor for creditor-placed insurance coverage that exceeds a term of one (1) year, the debtor shall be notified at least annually that the insurance will be canceled and a refund or credit of unearned charges made if evidence of acceptable insurance secured by the debtor is provided.

**SOURCES: Laws, 2001, ch. 307, § 4, eff from and after July 1, 2001.**

**Cross References —** Statement of refund not required if policy terminates pursuant to subsection (2) of this section, see § 83-54-17.

## § 83-54-9. Insurance premiums.

(1) Premiums for creditor-placed insurance coverage may be calculated based on:

(a) An amount not exceeding the net debt even though the coverage may limit the insurer's liability to the net debt, actual cash value or cost of repair; or

(b) Other premium calculation methods that more closely reflect the exposure of each item insured and approximate the premium calculation method of the coverage required by the credit agreement.

(2) An insurer shall not write creditor-placed insurance for which the premium rate differs from that determined by the schedules of the insurer on file and approved by the commissioner. The premium or amount charged to the debtor for creditor-placed insurance shall not exceed the premiums charged by the insurer, computed at the time the charge to the debtor is determined.

(3) A method of billing insurance charges to the debtor on closed-end credit transactions that creates a balloon payment at the end of the credit transaction or extends the credit transaction's maturity date is prohibited, unless specifically disclosed at the time of the origination of the credit agreement.

**SOURCES: Laws, 2001, ch. 307, § 5, eff from and after July 1, 2001.**

## § 83-54-11. Exclusions from coverage.

(1) Creditor-placed insurance coverage shall not include:

(a) Coverage for the cost of repossession;

(b) Skip, confiscation and conversion coverage;

(c) Coverage for payment of mechanics' or other liens that do not arise from a covered loss occurrence;

(d) Coverage that requires a debtor's insurance deductible to be less than Two Hundred Dollars ($200.00); or

(e) Coverage that is broader than the insurance coverages that meet the minimum insurance requirements of the credit agreement.

(2) Nothing in this section shall be deemed to prohibit the issuance of a separate policy or endorsement providing the coverages listed in subsection (1) of this section. However, no charge shall be passed along to the debtor for the coverages.

**SOURCES: Laws, 2001, ch. 307, § 6, eff from and after July 1, 2001.**

## § 83-54-13. Evidence of insurance coverage.

Creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance coverage or other evidence of insurance coverage shall be mailed, first-class mail, or delivered in person to the last known address of the debtor.

**SOURCES: Laws, 2001, ch. 307, § 7, eff from and after July 1, 2001.**

## § 83-54-15. Policy forms, certificates of insurance, and schedules of premium rates to be filed with Commissioner of Insurance; disapproval of forms or schedules; schedules not to be excessive, inadequate, or unfairly discriminatory; withdrawal of approval of approved forms or schedules; approved forms and schedules deemed to be in compliance with laws of the state.

(1) All policy forms and certificates of creditor-placed insurance to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Commissioner of Insurance.

(2) The commissioner shall within thirty (30) days after the filing of the policy forms and certificates of insurance disapprove a form that does not conform to this chapter or to other applicable provisions of the insurance statutes and regulations and shall, within thirty (30) days of filing, disapprove a schedule of premium rates pertaining to the form if it does not conform to the standard set forth in subsection (5).

(3) If the commissioner disapproves a form or schedule of premium rates in accordance with subsection (2), the commissioner shall promptly notify the insurer in writing of the disapproval, and it shall be unlawful for the insurer to issue or use the form or schedule. In the notice, the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within sixty (60) days after receipt of request in writing by the insurer.

(4) Unless the commissioner disapproves the form or schedule of premium rates in accordance with subsections (2) and (3) or gives written approval of the form or schedule within thirty (30) days after the filing, the form or schedule shall be deemed approved on the thirty-first day after the filing. However, within thirty (30) days after receiving a filing, the commissioner may issue a notice which delays the effective date of a filing for not more than thirty (30) days after the notice is issued if the commissioner determines that additional information or clarification concerning the rate or policy form is required.

(5) The schedules of premium rates shall not be excessive, inadequate or unfairly discriminatory. In determining whether a schedule of premium rates are excessive, inadequate or unfairly discriminatory, the commissioner shall take into account past and prospective loss experience, general and administrative expenses, loss settlement and adjustment expenses, reasonable creditor compensation and other acquisition costs including insurance tracking costs, reserves, taxes, licenses, fees and assessments, reasonable insurer profit and other relevant data. Rates are not unfairly discriminatory because different premiums result for different policyholders, including group policyholders, with similar loss exposures but different expense factors or similar expense factors but different loss exposures, nor are rates unfairly discriminatory if they are averaged broadly among all persons insured in this state or all persons insured under a group insurance policy.

(6) The commissioner may withdraw approval of an approved form or schedule of premium rates when the commissioner would be required to

disapprove the form or schedule of premium rates if it were filed at the time of the withdrawal. The withdrawal shall be in writing and shall specify the reasons for withdrawal and the effective date of the withdrawal. An insurer adversely affected by a withdrawal may, within thirty (30) days after receiving the written notification of the withdrawal, request in writing a hearing to determine whether the withdrawal should be annulled, modified or confirmed. Unless the commissioner grants an extension in writing in the withdrawal or subsequently grants an extension the withdrawal shall, in the absence of a request for hearing, become effective, prospectively and not retroactively, on the ninety-first day following delivery of the notice of withdrawal and, if the request for hearing is filed, on the ninety-first day following delivery of written notice of the commissioner's determination.

(7) Forms and rates filed and approved in accordance with this section shall be deemed to be in compliance in all respects with the laws of this state.

**SOURCES: Laws, 2001, ch. 307, § 8, eff from and after July 1, 2001.**

## § 83-54-17. Insurer to refund unearned premiums within 60 days after termination of coverage; statement of refund provided to debtor.

(1) Within sixty (60) calendar days after the termination of creditor-placed insurance coverage, and in accordance with the formulas approved by the commissioner, an insurer shall refund any unearned premium or other identifiable charges.

(2) Within sixty (60) calendar days after the termination date of creditor-placed insurance coverage, the insurer or creditor shall provide to the debtor a statement of refund disclosing the effective date, the termination date, the amount of premium being refunded and the amount of premium charged for the coverage provided. No statement shall be required in the event that the policy terminates pursuant to Section 83-54-7(2)(d).

(3) The entire amount of premiums, minimum premiums, fees or charges of any kind shall be refunded if no coverage was provided.

**SOURCES: Laws, 2001, ch. 307, § 9, eff from and after July 1, 2001.**

## § 83-54-19. Payment by insurer in the event of loss.

(1) In the event of a loss under the creditor-placed insurance policy, the insurer shall pay, at a minimum, the least of the following, the value of which shall be determined as of the date of loss and shall be reduced by any payments to the creditor or debtor recovered from a third party:

(a) The cost to repair the collateral, less any applicable deductible;

(b) The actual cash value of the collateral, less any applicable deductible;

(c) The net debt, less any applicable deductible; or

(d) If single interest insurance is provided, the amount by which the creditor's interest is impaired.

(2) The net debt or actual cash value amounts in subsection (1) may be reduced by the value of salvage if the insurer does not take possession of the insured property. This does not preclude the borrower's right to retain possession of the damaged collateral, if desired.

(3) In the event of a loss, no subrogation shall run against the debtor from the insurer.

(4) Whenever a claim is made on a creditor-placed insurance policy, the insurer shall furnish to the creditor a written statement of the loss explaining the settlement amount and the method of settlement, and the creditor shall furnish this information to the debtor.

(5) A creditor or insurer may not abandon salvage to a towing or storage facility in lieu of payment of storage fees without the consent of the facility and the claimant. The insurer shall be responsible for the payment of towing and storage charges for a covered loss occurrence from the time the claim is reported to the insurer in accordance with the terms of the policy to the time the claim is paid. After the claim is paid, the debtor shall be responsible for the payment of any towing or storage charges.

**SOURCES: Laws, 2001, ch. 307, § 10; Laws, 2005, ch. 311, § 1, eff from and after July 1, 2005.**

## § 83-54-21. Prerequisites for creditor to insure collateral; right of debtor to insure collateral.

(1) In order for the creditor to place insurance on the collateral pledged by the debtor and pass the cost of the insurance on to the debtor:

(a) The creditor must have a security interest in the personal property;

(b) The credit agreement must require the debtor to maintain insurance on the collateral to protect the creditor's interest;

(c) The credit agreement must authorize the creditor to place the insurance if the debtor fails to provide evidence of the insurance; and

(d) The information set forth in paragraphs (a) through (c) of this subsection (1) must be clearly disclosed to the debtor at the inception of the credit transaction.

(2) The debtor shall always have the right to provide required insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through an insurer authorized to transact insurance within this state. However, a creditor may establish maximum acceptable deductibles, insurer solidity standards and other reasonable conditions with respect to the required insurance.

**SOURCES: Laws, 2001, ch. 307, § 11, eff from and after July 1, 2001.**

### § 83-54-23. Entire amount of premium due shall be remitted to insurer in accordance with insurer's requirements; creditor prohibited from retaining unearned premiums upon cancellation without crediting debtor's account; rebates to creditor prohibited.

(1) The entire amount of the premium due from a creditor shall be remitted to the insurer or its producer in accordance with the insurer's requirements. No commissions may be paid to, or retained by, a person or entity except a licensed and appointed insurance producer.

(2) The retention by the creditor of unearned premiums upon cancellation of the insurance without crediting to the debtor's account the amount of unearned insurance charges is prohibited.

(3) Rebates to the creditor of a portion of the premium charged to the debtor are prohibited as are other inducements provided to the creditor by an insurer or producer. The listing of the following activities as prohibited rebates or inducements is not intended to be restrictive, and the commissioner may identify an activity as prohibited by rule, regulation or order:

(a) Allowing insurers or producers to purchase certificates of deposit from the creditor or to maintain accounts with the creditor at less than the market interest rates and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration; and

(b) Paying a commission to a person, including a creditor, who is not appropriately licensed as a producer in this state.

(4) Prohibited rebates or inducements do not include:

(a) The providing of insurance tracking and other services incidental to the creditor-placed insurance program;

(b) The paying of commissions and other compensation to a duly licensed and appointed insurance producer, whether or not affiliated with the creditor;

(c) The paying to the creditor policyholder of group experience rated refunds or policy dividends; and

(d) The paying to the creditor of amounts intended to reimburse the creditor for its expenses incurred incidental to the creditor-placed insurance program (such as costs of data processing, mail processing, telephone service, insurance tracking, billing, collections and related activities); provided that these payments are calculated in a manner that does not exceed an amount reasonably estimated to equal the expenses incurred by the creditor.

(5) Nothing contained in this section shall prohibit or restrict an insurer or producer from maintaining a demand, premium deposit or other account or accounts with a creditor for which the insurer or agent provides insurance if the accounts pay the market interest rate and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration.

**SOURCES: Laws, 2001, ch. 307, § 12, eff from and after July 1, 2001.**

### § 83-54-25. Creditor to make adequate disclosure to debtor of insurance requirement; "adequate disclosure" defined; when creditor may impose charges; "reasonable efforts" to notify debtor; form of notice; evidence of insurance coverage; creditor not required to insure collateral.

(1) A creditor shall not impose charges, including premium costs and related interest and finance charges, on a debtor for creditor-placed insurance coverage unless adequate disclosure of the requirement to maintain insurance has been made to the debtor. Adequate disclosure is accomplished if the following occurs:

(a) The credit agreement sets forth the requirement that the debtor must maintain insurance on the collateral as provided for in Section 83-54-21;

(b) The creditor makes reasonable efforts to notify the debtor of the requirement to maintain insurance and allows a reasonable time for compliance with this requirement;

(c) A final notice as required by this chapter is sent to the debtor; and

(d) If creditor-placed insurance coverage is issued, a copy of the policy or certificate, with disclosure of premium charged, is sent to the debtor as provided for in Section 83-54-13.

(2) After adequate disclosure of the request to maintain insurance has been made to the debtor as required by this section, a creditor may proceed to impose charges for creditor-placed insurance if the debtor fails to provide evidence of insurance. A creditor may impose charges no earlier than ten (10) calendar days after sending the final notice. However, the charges can be retroactive to the date of exposure to loss.

(3) Reasonable efforts to notify the debtor are accomplished if:

(a) The creditor mails a notice by first-class mail to the debtor's last known address as contained in the creditor's records, stating that the creditor intends to charge the debtor for creditor-placed insurance coverage on the collateral if the debtor fails to provide evidence of the property insurance to the creditor;

(b) The creditor allows the debtor at least twenty (20) calendar days to respond to the notice and provide evidence of acceptable insurance coverage before sending a final notice; and

(c) The creditor sends a final notice in compliance with this section by first-class mail to the debtor's last known address as contained in the creditor's records at least ten (10) calendar days before the cost of insurance is charged to the debtor by the creditor. Proof of the mailing of the final notice shall be retained for at least three (3) years following the expiration or termination of the coverage or as otherwise required by law. A register of letters shall be deemed sufficient proof to satisfy this requirement.

(4) The initial notice shall be in a form determined by the creditor to remind the debtor of the requirement to maintain insurance on the collateral. The final notice shall be as complete as the following notice, printed in not less

than twelve (12) point type, and modified where necessary to fit the nature of the credit transaction:

> "FINAL NOTICE
>
> Your credit agreement with us requires you to have property insurance on the collateral until you pay off your loan. You have not given us proof you have insurance on the property. You can ask your insurance company or agent to give us proof of insurance or you can send us proof you have property insurance within ten (10) calendar days after the date this letter was postmarked. If you do not, we will charge you for the insurance we buy.
>
> You must pay for the property insurance we buy. It may cost more than insurance you can buy on your own. The premium of the insurance we buy may be added to your loan balance and we may charge you interest on it. You will be charged interest on the premium at the rate of ______ per annum.
>
> The insurance we buy will pay claims to us (the creditor) for physical damage to your property. It will not pay any claims made against you and it may not pay you for any claims you make. The insurance we buy will not give you any liability insurance coverage and will not meet any other requirements of state law.
>
> We may receive compensation for placing this insurance, which is included in the cost of coverage charged to you.
>
> The property coverage we buy will start on the date shown in the policy or certificate, which may go back to the date of the loan or the date your prior coverage stopped. We will cancel the insurance we bought for you and give you a refund or credit of unearned charges if you give us proof you have bought property insurance somewhere else or if you have paid off the loan."

(5) All creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. Not earlier than the sending of the final notice nor fifteen (15) days after a charge is made to the debtor for creditor-placed insurance coverage, the creditor shall cause a copy of the individual policy, certificate or other evidence of insurance coverage evidencing the creditor-placed insurance coverage to be sent, first-class mail, to the debtor's last known address.

(6) A creditor's compliance with or failure to comply with this chapter shall not be construed to require the creditor to purchase insurance coverage on the collateral, and the creditor shall not be liable to the debtor or a third party as a result of its failure to purchase the insurance.

**SOURCES: Laws, 2001, ch. 307, § 13, eff from and after July 1, 2001.**

**Joint Legislative Committee Note** — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error in (1)(a) and (d). In (1)(a), the words "Section 11 of this chapter" were changed to "Section 83-54-21." In (1)(d), the words "Section 7 of this chapter" were changed to "Section 83-54-13." The Joint Committee ratified the correction at its July 8, 2004, meeting.

### § 83-54-27. Commissioner of Insurance authorized to conduct investigations of insurers and producers, to deny, suspend, or revoke certificates of authority or producer's licenses, and to impose civil penalties; judicial review of commissioner's orders.

(1) The commissioner may conduct investigations and/or examinations of insurers and producers to ensure compliance with the provisions of this chapter or any rule, regulation or order hereunder, as well as under any other applicable statutes or regulations.

(2) The commissioner may by order, deny, suspend or revoke an insurer's certificate of authority or a producer's license if the commissioner finds that such insurer or producer has violated any provision of this chapter.

(3) If the commissioner has reason to believe that any person or entity is engaging in any activity that would be a violation of this chapter or any rule promulgated under this chapter, the commissioner may issue an order directing that person or entity to cease and desist from committing the violations, impose a civil penalty for the violations, provide an equitable remedy for past violations, or any combination of these. Such order may be issued without prior notice if the commissioner makes a finding that such order is necessary for the protection of policyholders and that the public health, safety and welfare require the order to be issued without prior notice to affected parties. At any hearing or other proceeding conducted as a result of an order to cease and desist, pursuant to this chapter, the person or entity subject to the order shall be required to show cause why such order should be annulled, modified or confirmed.

(4) Whenever it appears to the commissioner that any person or entity has engaged or is about to engage in an act of practice constituting a violation of any provision of this chapter or any rule, regulation or order hereunder, the commissioner may, in the commissioner's discretion, bring an action in chancery court of any county in this state to enjoin the acts or practices and to enforce compliance with this chapter or any rule, regulation or order hereunder. Upon a proper showing, a permanent or temporary injunction, restraining order, writ of mandamus, disgorgement or other proper equitable relief shall be granted.

(5) Additionally, upon a finding that any person or entity has violated a provision of this chapter, the commissioner may impose a civil penalty of not more than One Thousand Dollars ($1,000.00) for each violation, and may revoke, suspend or decline to renew any license of such person or entity to sell or issue insurance.

(6) Any person aggrieved by a final order of the commissioner under this chapter may obtain judicial review of the order in the Circuit Court of Hinds County by filing, within thirty (30) days of the issuance and service of such

order, a written petition or complaint praying that said order be modified or set aside. A copy of such petition shall be served upon the commissioner, and the commissioner shall file a complete record of the proceedings with said court, which shall then have jurisdiction of the proceedings and questions determined therein.

**SOURCES: Laws, 2001, ch. 307, § 14, eff from and after July 1, 2001.**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error in (1) and (2). The words "the act" were changed to "this chapter." The Joint Committee ratified the correction at its July 8, 2004, meeting

## § 83-54-29. Rules and regulations.

The commissioner is authorized after notice and hearing to promulgate rules and regulations to effectuate the purposes of this chapter. The commissioner may require such information as is reasonably necessary for the enforcement of this chapter. All rules and regulations adopted and promulgated pursuant to this chapter shall be subject to the Mississippi Administrative Procedures Law, Section 25-43-1 et seq.

**SOURCES: Laws, 2001, ch. 307, § 15, eff from and after July 1, 2001.**

**Editor's Note —** Section 25-43-1.101(3) provides that any reference to Section 25-43-1 et seq. shall be deemed to mean and refer to Section 25-43-1.101 et seq.

## § 83-54-31. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are declared to be severable.

**SOURCES: Laws, 2001, ch. 307, § 16, eff from and after July 1, 2001.**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error. The word "act" was changed to "chapter."The Joint Committee ratified the correction at its July 8, 2004, meeting.

## CHAPTER 55

## Risk Retention Act

Sec.
83-55-1. Purpose.
83-55-3. Definitions.
83-55-5. Chartering of risk retention groups; submission of plan of operation; revisions of plan; information required.
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83-55-21. Powers of commissioner; applicable procedures; injunctive relief.
83-55-23. License required to solicit, negotiate or procure liability insurance; notice to insured.
83-55-25. U.S. District Court injunctions enforceable in state courts.
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83-55-29. Saving clause.

### § 83-55-1. Purpose.

The purpose of this chapter is to regulate the formation and/or operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 ("RRA 1986"), to the extent permitted by such law.

**SOURCES: Laws, 1988, ch. 419, § 1, eff from and after July 1, 1988.**

**Federal Aspects —** The Liability Risk Retention Act of 1986 is codified in 15 USCS § 3901 et seq.

#### RESEARCH REFERENCES

**Practice References.** Business Law Monographs, Volume IN2 — Casualty and Liability Insurance (Matthew Bender).

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

### § 83-55-3. Definitions.

For the purposes of this chapter, the following words shall have the meanings ascribed herein, unless the context otherwise requires:

(a) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(b) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

(i) Any person who performs that work; or

(ii) Any person who hires an independent contractor to perform that work, but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(c) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

(i) For a corporation, the state in which the purchasing group is incorporated; and

(ii) For an unincorporated entity, the state of its principal place of business.

(d) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

(i) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(ii) To pay other obligations in the normal course of business.

(e) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(f) "Liability"

(i) Means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:

1. Any business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations; or

2. Any activity of any state or local government, or any agency or political subdivision thereof; and

(ii) Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq).

(g) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in subparagraph (vi) of paragraph 2(h).

(h) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(i) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

(ii) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;

(iii) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(iv) Pro forma financial statements and projections;

(v) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(vi) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

(vii) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

(viii) Such other matters as may be prescribed by the Commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

(i) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such person when the incident giving rise to the claim occurred.

(j) "Purchasing group" means any group which:

(i) Has as one (1) of its purposes the purchase of liability insurance on a group basis;

(ii) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in subparagraph (iii);

(iii) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and

(iv) Is domiciled in any state.

(k) "Risk retention group" means any corporation or other limited liability association:

(i) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(ii) Which is organized for the primary purpose of conducting the activity described under subparagraph (i);

(iii) Which:

1. Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

2. Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the Insurance Commissioner of at least one (1) state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986);

(iv) Which does not exclude any person from membership in the group solely to provide for members of such group a competitive advantage over such person;

(v) Which:

1. Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

2. Has as its sole owner an organization which has as:

a. Its members only persons who comprise the membership of the risk retention group; and

b. Its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(vi) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

(vii) Whose activities do not include the provision of insurance other than:

1. Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

2. Reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that such group or member meets the requirement described in subparagraph (vi) from membership in the risk retention group which provides such reinsurance; and

(viii) The name of which includes the phrase "Risk Retention Group."

(*l*) "State" means any state of the United States or the District of Columbia.

**SOURCES: Laws, 1988, ch. 419, § 2, eff from and after July 1, 1988.**

**Cross References** — Requirement that out-of-state chartered and licensed risk retention groups submit information verifying that they qualify under this section as a "risk retention group," see § 83-55-7.

Requirement that purchasing groups provide information verifying that they qualify as a "purchasing group" under this section, see § 83-55-15.

**Federal Aspects** — Product Liability Risk Retention Act of 1981 is codified as 15 USCS § 3901 et seq.

Liability Risk Retention Act of 1986 is codified in 15 USCS § 3901 et seq., effective October 27, 1986.

Federal Employers' Liability Act is codifies in 45 USCS § 51 et seq.

RESEARCH REFERENCES

**ALR.** Excessiveness or adequacy of damages awarded for injuries to nerves or nervous system. 51 A.L.R.5th 467.

Excessiveness or adequacy of damages awarded for injuries causing mental or psychological damages. 52 A.L.R.5th 1.

Requirement that multicoverage umbrella insurance policy offer uninsured-or underinsured-motorist coverage equal to liability limits under umbrella provisions. 52 A.L.R.5th 451.

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

## § 83-55-5. Chartering of risk retention groups; submission of plan of operation; revisions of plan; information required.

(1) A risk retention group shall, pursuant to the provisions of the laws of this state be chartered and licensed to write only liability insurance pursuant to this chapter and, except as provided elsewhere in this chapter, must comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state and with Section 83-55-7 to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

(2) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Insurance Commissioner of this state a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of such plan or study is approved by the Commissioner.

(3) At the time of filing its application for charter, the risk retention group shall provide to the Commissioner in summary form the following information: The identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the National Association of Insurance Commissioners (NAIC). Providing notification to the National Association of Insurance Commissioners is in addition to and shall

not be sufficient to satisfy the requirements of Section 83-55-7 or any other sections of this chapter.

**SOURCES: Laws, 1988, ch. 419, § 3, eff from and after July 1, 1988.**

**Cross References** — Requirement that risk retention groups submit a copy of any revision to the plan of operation required by this section, see § 83-55-7.

## § 83-55-7. Out-of-state chartered risk retention groups; requirements for doing business in state.

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

(a) Notice of operations and designation of Commissioner as agent.

(i) Before offering insurance in this state, a risk retention group shall submit to the Commissioner:

1. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and such other information, including information on its membership, as the Commissioner of this state may require to verify that the risk retention group is qualified under Section 83-55-3(k);

2. A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

a. Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

b. Was offered before such date by any risk retention group which had been chartered and operating for not less than three (3) years before such date; and

(ii) The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by Section 83-55-5(2) at the same time that such revision is submitted to the Commissioner of its chartering state.

(iii) A statement of registration, for which a filing fee shall be determined by the Commissioner, which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process.

(b) Financial condition. Any risk retention group doing business in this state shall submit to the Commissioner:

(i) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners);

(ii) A copy of each examination of the risk retention group as certified by the Commissioner or public official conducting the examination;

(iii) Upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

(iv) Such information as may be required to verify its continuing qualification as a risk retention group under Section 83-55-3(k).

(c) Taxation.

(i) Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state, and shall report to the Commissioner the net premiums written for risks resident or located within this state. Such risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

(ii) To the extent licensed agents or brokers are utilized pursuant to Section 83-55-23, they shall report to the Commissioner the premiums for direct business for risks resident or located within this state which such licensees have placed with or on behalf of a risk retention group not chartered in this state.

(iii) To the extent that insurance agents or brokers are utilized pursuant to Section 83-55-23, such agent or broker shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the Commissioner, as provided in Section 83-5-65, Mississippi Code of 1972. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

1. The limit of liability;
2. The time period covered;
3. The effective date;
4. The name of the risk retention group which issued the policy;
5. The gross premium charged; and
6. The amount of return premiums, if any.

(d) Deceptive, false or fraudulent practices. Any risk retention group shall comply with Sections 83-5-29 through 83-5-51, Mississippi Code of 1972, regarding deceptive, false or fraudulent acts or practices. However, if the Commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(e) Examination regarding financial condition. Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the Commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

(f) Notice to Purchasers. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in ten-point type the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(g) Prohibited acts regarding solicitation or sale. The following acts by a risk retention group are hereby prohibited:

(i) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(ii) The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

(h) Prohibition on ownership by an insurance company. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(i) Prohibited coverage. The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

(j) Delinquency proceedings. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a State Insurance Commissioner if there has been a finding of financial impairment after an examination.

(k) Penalties. A risk retention group that violates any provision of this chapter will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally.

(*l*) Operation prior to July 1, 1988. In addition to complying with the requirements of this section, any risk retention group operating in this state prior to July 1, 1988, shall, within thirty (30) days after July 1, 1988, comply with the provision of paragraph (a)(i) of this section.

**SOURCES: Laws, 1988, ch. 419, § 4, eff from and after July 1, 1988.**

**Cross References** — Requirement that risk retention groups comply with the provisions of this section, and exceptions thereto, see § 83-55-5.

Provision that notice to the National Association of Insurance Commissioners (NAIC) is not sufficient to satisfy the requirements of this section, see § 83-55-5.

Requirement that each prospective insured be informed of the provisions of the notice required by this section, see § 83-55-23.

**Federal Aspects —** The Product Liability Risk Retention Act of 1981 is codified as 15 USCS §§ 3901 et seq.

## § 83-55-9. Risk retention groups not to participate in insolvency guaranty funds; no benefits to be received from funds.

(1) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

(2) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

(3) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by any state guaranty fund.

**SOURCES: Laws, 1988, ch. 419, § 5, eff from and after July 1, 1988.**

## § 83-55-11. Policy not required to be countersigned.

A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned.

**SOURCES: Laws, 1988, ch. 419, § 6, eff from and after July 1, 1988.**

## § 83-55-13. Purchasing group and insurer subject to all applicable state laws; exceptions.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

(a) Prohibit the establishment of a purchasing group;

(b) Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

(c) Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph (b) of this section;

(d) Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(e) Require that a purchasing group must have a minimum number of members, common ownership or affiliation or certain legal form;

(f) Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

(g) Otherwise discriminate against a purchasing group or any of its members; or

(h) Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

**SOURCES: Laws, 1988, ch. 419, § 7, eff from and after July 1, 1988.**

## § 83-55-15. Purchasing group; notice of intent to do business; commissioner as agent for service; additional information required; preexisting groups.

(1) A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the Commissioner which shall:

(a) Identify the state in which the group is domiciled;

(b) Identify all other states in which the group intends to do business;

(c) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(d) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

(e) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(f) Identify the principal place of business of the group; and

(g) Provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under Section 83-55-3(j).

(2) A purchasing group shall, within ten (10) days, notify the Commissioner of any changes in any of the items set forth in subsection (1) of this section.

(3) The purchasing group shall register with and designate the Commissioner (or other appropriate authority) as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be determined by the Commissioner, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the Federal Products Liability Risk Retention Act of 1981, and

(a) Which in any state of the United States:

(i) Was domiciled before April 1, 1986; and

(ii) Is domiciled on and after October 27, 1986;

(b) Which:

(i) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

(ii) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

(c) Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

(4) Each purchasing group that is required to give notice pursuant to subsection (1) of this section shall also furnish such information as may be required by the Commissioner to:

(a) Verify that the entity qualifies as a purchasing group;

(b) Determine where the purchasing group is located; and

(c) Determine appropriate tax treatment.

(5) Any purchasing group which was doing business in this state prior to July 1, 1988, shall, within thirty (30) days after July 1, 1988, furnish notice to the Commissioner pursuant to the provisions of subsection (1) of this section and furnish such information as may be required pursuant to subsections (2) and (3) of this section.

**SOURCES: Laws, 1988, ch. 419, § 8, eff from and after July 1, 1988.**

**Federal Aspects —** The Product Liability Risk Retention Act of 1981 is codified as 15 USCS § 3901 et seq.

## § 83-55-16. Payment of annual fee to continue to do business in state; penalties for failure to pay fee; filing of annual reports.

(1) Each risk retention group or risk purchasing group which wishes to do or continue to do business in this state shall annually register on or before March 1 of each year. Should a risk retention group or risk purchasing group fail to timely register, the commissioner shall immediately revoke without notice or hearing any registration held by the entity.

(2) Each risk retention group or risk purchasing group operating in the State of Mississippi shall file with the Mississippi Department of Insurance on or before March 1 of each year a listing of the premiums written on risks in Mississippi.

**SOURCES: Laws, 1999, ch. 343, § 1; Laws, 2006, ch. 496, § 1, eff from and after July 1, 2006.**

## § 83-55-17. Purchase of insurance from non-state chartered group or non-state admitted insurer; notice requirements; deductible or self-insured retention not permitted; aggregate limits on purchases.

(1) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected

through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

(2) A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of such group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

(3) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

(4) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

**SOURCES: Laws, 1988, ch. 419, § 9, eff from and after July 1, 1988.**

**Cross References —** Requirement that each prospective insured be informed of the provisions of the notice required by this section, see § 83-55-23.

### RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

## § 83-55-19. Premium taxes.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups shall be:

(a) Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(b) Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

**SOURCES: Laws, 1988, ch. 419, § 10, eff from and after July 1, 1988.**

## § 83-55-21. Powers of commissioner; applicable procedures; injunctive relief.

The Commissioner is authorized to make use of any of the powers established under the Insurance Laws of this state to enforce the laws of this state not specifically preempted by the Risk Retention Act of 1986, including the Commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the Commissioner can rely on the procedural laws of this state. The injunctive authority of the Commissioner, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

**SOURCES: Laws, 1988, ch. 419, § 11, eff from and after July 1, 1988.**

**Federal Aspects** — Risk Retention Act of 1986 is codified as 15 USCS § 3901 et seq.

## § 83-55-23. License required to solicit, negotiate or procure liability insurance; notice to insured.

(1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state from a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(2) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(3) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance coverage in this state for any member of a purchasing group under a purchasing group's policy unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(4) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless such person, firm, association or corporation is licensed as a surplus lines agent or excess line broker in accordance with the laws of this state.

(5) For purposes of acting as an agent or broker for a risk retention group or purchasing group pursuant to subsections (1) and (2) of this section, the requirement of residence in this state shall not apply.

(6) Every person, firm, association or corporation licensed pursuant to the laws of this state, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by paragraph (f) of Section 83-55-7 in the case of a risk retention group and subsection (2) of Section 83-55-17 in the case of a purchasing group.

**SOURCES: Laws, 1988, ch. 419, § 12, eff from and after July 1, 1988.**

**Cross References** — Reporting and record keeping requirements applicable to agents and brokers utilized pursuant to this section, see § 83-55-7.

RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

## § 83-55-25. U.S. District Court injunctions enforceable in state courts.

An order issued by any District Court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states or in any territory or possession of the United States) upon a finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the courts of this state.

**SOURCES: Laws, 1988, ch. 419, § 13, eff from and after July 1, 1988.**

## § 83-55-27. Rules and regulations.

The Commissioner may establish and from time to time amend such rules and regulations relating to risk retention groups as may be necessary or desirable to carry out the provisions of this chapter.

**SOURCES: Laws, 1988, ch. 419, § 14, eff from and after July 1, 1988.**

## § 83-55-29. Saving clause.

If any clause, sentence, paragraph, section or part of this chapter or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this chapter, and the application thereof to other persons or circumstances, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved.

**SOURCES: Laws, 1988, ch. 419, § 15, eff from and after July 1, 1988.**

## CHAPTER 57

## Home Warranties
## [Repealed]

### §§ 83-57-1 through 83-57-79. Repealed.

Repealed by Laws, 2003, ch. 386, § 2, eff from and after March 14, 2003.

§ 83-57-1. [Laws, 1988, ch. 525, § 1, eff from and after July 1, 1988.]

§ 83-57-3. [Laws, 1988, ch. 525, § 2, eff from and after July 1, 1988.]

§ 83-57-5. [Laws, 1988, ch. 525, § 3, eff from and after July 1, 1988.]

§ 83-57-7. [Laws, 1988, ch. 525, § 4, eff from and after July 1, 1988.]

§ 83-57-9. [Laws, 1988, ch. 525, § 5, eff from and after July 1, 1988.]

§ 83-57-11. [Laws, 1988, ch. 525, § 6, eff from and after July 1, 1988.]

§ 83-57-13. [Laws, 1988, ch. 525, § 7, Laws 1999, ch. 346, § 1, eff from and after July 1, 1988.]

§ 83-57-15. [Laws, 1988, ch. 525, § 8, eff from and after July 1, 1988.]

§ 83-57-17. [Laws, 1988, ch. 525, § 9, eff from and after July 1, 1988.]

§ 83-57-19. [Laws, 1988, ch. 525, § 10, eff from and after July 1, 1988.]

§ 83-57-21. [Laws, 1988, ch. 525, § 11, eff from and after July 1, 1988.]

§ 83-57-23. [Laws, 1988, ch. 525, § 12, eff from and after July 1, 1988.]

§ 83-57-25. [Laws, 1988, ch. 525, § 13, eff from and after July 1, 1988.]

§ 83-57-27. [Laws, 1988, ch. 525, § 14, eff from and after July 1, 1988.]

§ 83-57-29. [Laws, 1988, ch. 525, § 15, eff from and after July 1, 1988.]

§ 83-57-31. [Laws, 1988, ch. 525, § 16; Laws, 1999, ch. 315, § 1, eff from and after July 1, 1999.]

§ 83-57-33. [Laws, 1988, ch. 525, § 17, eff from and after July 1, 1988.]

§ 83-57-35. [Laws, 1988, ch. 525, § 18, eff from and after July 1, 1988.]

§ 83-57-37. [Laws, 1988, ch. 525, § 19, eff from and after July 1, 1988.]

§ 83-57-39. [Laws, 1988, ch. 525, § 20, eff from and after July 1, 1988.]

§ 83-57-41. [Laws, 1988, ch. 525, § 21, eff from and after July 1, 1988.]

§ 83-57-43. [Laws, 1988, ch. 525, § 22, eff from and after July 1, 1988.]

§ 83-57-45. [Laws, 1988, ch. 525, § 23, eff from and after July 1, 1988.]

§ 83-57-47. [Laws, 1988, ch. 525, § 24, eff from and after July 1, 1988.]

§ 83-57-49. [Laws, 1988, ch. 525, § 25, eff from and after July 1, 1988.]

§ 83-57-51. [Laws, 1988, ch. 525, § 26, eff from and after July 1, 1988.]

§ 83-57-53. [Laws, 1988, ch. 525, § 27, eff from and after July 1, 1988.]

§ 83-57-55. [Laws, 1988, ch. 525, § 28, eff from and after July 1, 1988.]

§ 83-57-57. [Laws, 1988, ch. 525, § 29, eff from and after July 1, 1988.]

§ 83-57-59. [Laws, 1988, ch. 525, § 30, eff from and after July 1, 1988.]

§ 83-57-61. [Laws, 1988, ch. 525, § 31, eff from and after July 1, 1988.]

§ 83-57-63. [Laws, 1988, ch. 525, § 32, eff from and after July 1, 1988.]

§ 83-57-65. [Laws, 1988, ch. 525, § 33, eff from and after July 1, 1988.]

§ 83-57-67. [Laws, 1988, ch. 525, § 34, eff from and after July 1, 1988.]

§ 83-57-69. [Laws, 1988, ch. 525, § 35, eff from and after July 1, 1988.]

§ 83-57-71. [Laws, 1988, ch. 525, § 36, eff from and after July 1, 1988.]

§ 83-57-73. [Laws, 1988, ch. 525, § 37, eff from and after July 1, 1988.]

§ 83-57-75. [Laws, 1988, ch. 525, § 38, eff from and after July 1, 1988.]

§ 83-57-77. [Laws, 1988, ch. 525, § 39, eff from and after July 1, 1988.]

§ 83-57-79. [Laws, 1988, ch. 525, § 40, eff from and after July 1, 1988.]

**Editor's Note** — Laws of 2003, ch. 386, § 3, provides:

"SECTION 3. This act shall take effect and be in force from and after its passage, and shall be applicable to all proceedings pending before the Department of Insurance or the courts of this state on the effective date of this act." Laws of 2003, ch. 386, became effective upon the signature of the Governor on March 14, 2003.

Former §§ 83-57-1 through 83-57-79 provided for the regulation of home warranties by the Commissioner of Insurance. For current similar provisions pertaining to regulation of service contracts, home warranties, and home service contracts under the Mississippi Consumer Protection Act, see § 75-24-91. For present provisions relating to new home warranties, see §§ 83-58-1 et seq.

Former § 83-57-1 was entitled: "Home warranties to be regulated by Insurance Department; vendors to be licensed."

Former § 83-57-3 was entitled: "Definitions."

Former § 83-57-5 was entitled: "Administration of chapter; rules and regulations."

Former § 83-57-7 was entitled: "License required to provide home warranties; exception; requirements for license."

Former § 83-57-9 was entitled: "Deposit of securities or bonds to assure performance."

Former § 83-57-11 was entitled: "Application for license; issuance, refusal, and renewal of license."

Former § 83-57-13 was entitled: "Funded, unearned premium reserve; net assets; liability insurance in lieu of reserve."

Former § 83-57-15 was entitled: "Grounds for revocation, suspension or refusal to renew license; notice and hearing requirements."

Former § 83-57-17 was entitled: "Notice of suspension or revocation of license."

Former § 83-57-19 was entitled: "Suspension of license; reinstatement of license."

Former § 83-57-21 was entitled: "Fine in lieu of suspension, revocation or refusal to renew; nonwillful violations; willful violations; restitution."

Former § 83-57-23 was entitled: "Warranty forms; filing requirements; disapproval of forms."

Former § 83-57-25 was entitled: "Filing of rate and premium schedules; approval or disapproval."

Former § 83-57-27 was entitled: "Filing of annual statement; information required; premium taxes."

Former § 83-57-29 was entitled: "Records."

Former § 83-57-31 was entitled: "Financial examinations of home warranty associations."

Former § 83-57-33 was entitled: "Service of process on home warranty associations."

Former § 83-57-35 was entitled: "Registration of sales representatives."

Former § 83-57-37 was entitled: "Funds received by sales representatives are trust funds; accounting for funds received; penalty for appropriating funds to own use."

Former § 83-57-39 was entitled: "Grounds for suspension, revocation or refusal to renew registration of sales representative."

Former § 83-57-41 was entitled: "Violations of chapter by representative; automatic revocation of registration; suspension of registration; reinstatement; revocation of registration; reregistration; former registrant not to engage in activities requiring registration."

Former § 83-57-43 was entitled: "Fine in lieu of suspension or revocation of, or refusal to renew, registration."

Former § 83-57-45 was entitled: "Taxes, fees, fines and penalties to be deposited to general fund."

Former § 83-57-47 was entitled: "Authorization under chapter limited to business of home warranty."

Former § 83-57-49 was entitled: "Fronting" company.

Former § 83-57-51 was entitled: "Chapter inapplicable to certain licensed insurers."

Former § 83-57-53 was entitled: "Penalty for making false application for registration or violating this chapter."

Former § 83-57-55 was entitled: "Civil action for violation of this chapter authorized; notice requirements; class actions not authorized."

Former § 83-57-57 was entitled: "Dissolution or liquidation of corporation subject to this chapter."

Former § 83-57-59 was entitled: "Unfair trade practice prohibited; unfair methods of competition and unfair or deceptive acts or practices defined."

Former § 83-57-61 was entitled: "Examinations and investigations of unfair trade practices."

Former § 83-57-63 was entitled: "Hearings; orders; penalties."

Former § 83-57-65 was entitled: "Appeal of order."

Former § 83-57-67 was entitled: "Penalties for violating order."

Former § 83-57-69 was entitled: "Injunction relief."

Former § 83-57-71 was entitled: "Provisions of chapter cumulative."

Former § 83-57-73 was entitled: "Lending of money or extension of credit conditioned on purchase of home warranty prohibited; notice to borrower or purchaser."

Former § 83-57-75 was entitled: "Notice or right to cancel home warranty purchased in connection with loan."

Former § 83-57-77 was entitled: "Confidentiality of records."

Former § 83-57-79 was entitled: "Ineligibility of certain persons to be licensed to sell home warranties."

# CHAPTER 58

## New Home Warranty Act

Sec.

83-58-1. Short title.

83-58-3. Definitions.

83-58-5. Builder's warranties to owner.

83-58-7. Written notice of defect to builder.

83-58-9. Commencement of warranty action.

83-58-11. Insurance for warranty allegations.

83-58-13. Transfer of warranties.

83-58-15. Damages; arbitration of claims.

83-58-17. Statutory remedy for damages arising from violations of home warranty law; common law remedies.

### § 83-58-1. Short title.

This chapter shall be known and may be cited as the "New Home Warranty Act."

**SOURCES: Laws, 1997, ch. 465, § 1, eff from and after July 1, 1997.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:

"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

#### RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Validity, construction, and application of new home warranty acts. 101 A.L.R.5th 447.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

### § 83-58-3. Definitions.

For purposes of this chapter the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Builder" means any person, corporation, partnership, or other entity which constructs a home or engages another to construct a home, including a home occupied initially by its builder as his residence, for the purpose of sale.

(b) "Building standards" means the standards contained in the building code, mechanical-plumbing code, and electrical code in effect in the county, municipality, or other local political subdivision where a home is to be located, at the time construction of that home is commenced, or, if the county, city, or other local political subdivision has not adopted such codes, the Standard Building Code, together with any additional performance standards, if any, which the builder may undertake to be in compliance.

(c) "Home" means any new structure designed and used only for residential use.

(d) "Initial purchaser" means any person for whom a home is built or the first person to whom a home is sold upon completion of construction.

(e) "Major structural defect" means any actual physical damage to the following designated load-bearing portions of a home caused by failure of the load-bearing portions which affects their load-bearing functions, as follows to wit:

(i) Foundation systems and footings;
(ii) Beams;
(iii) Girders;
(iv) Lintels;
(v) Columns;
(vi) Walls and partitions;
(vii) Floor systems;
(viii) Roof framing systems.

(f) "Owner" means the initial purchaser of a home and any of his successors in title to a home during the time the warranties provided under this chapter are in effect.

(g) "Warranty commencement date" means the date that legal title to a home is conveyed to its initial purchaser or the date the home is first occupied, whichever occurs first.

**SOURCES: Laws, 1997, ch. 465, § 2, eff from and after July 1, 1997.**

**Editor's Note —** Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

## JUDICIAL DECISIONS

**1. Building standards.**
Builder was liable to two owners for defects in a new home based on the contractual warranties and the one-year warranty set forth in Miss. Code Ann. § 83-58-5(1)(a) because the term "additional performance standards" in Miss. Code Ann. § 83-58-3(b) incorporated such matters that were set out in the contract, even though no violations of any building code were found. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140 (Miss. Ct. App. 2004).

## RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-5. Builder's warranties to owner.

(1) Subject to the exclusions provided in this section, every builder warrants the following to the owner:

(a) One (1) year following the warranty commencement date, the home will be free from any defect due to noncompliance with the building standards.

(b) Six (6) years following the warranty commencement date, the home will be free from major structural defects due to noncompliance with the building standards.

(2) Unless the parties otherwise agree in writing, the builder's warranty shall exclude the following items:

(a) Defects in outbuildings including detached garages and detached carports, except outbuildings which contain the plumbing, electrical, heating, cooling or ventilation systems serving the home; swimming pools and other recreational facilities; driveways; walkways; patios; boundary walls; retaining walls; bulkheads; fences; landscaping, including sodding, seeding, shrubs, trees, and planting; off-site improvements including streets, roads, drainage and utilities or any other improvements not a part of the home itself.

(b) Damage to real property which is not part of the home covered by the warranty and which is not included in the purchase price of the home.

(c) Any damage to the extent it is caused or made worse by any of the following:

(i) Negligence, improper maintenance or improper operation by anyone other than the builder or any employee, agent or subcontractor of the builder.

(ii) Failure by anyone other than the builder or any employee, agent or subcontractor of the builder to comply with the warranty requirements of manufacturers of appliances, equipment or fixtures.

(iii) Any change, alteration or addition made to the home by anyone after the initial occupancy by the owner, except any change, alteration or addition performed by the builder, or any employee, agent, or subcontractor of the builder.

(iv) Dampness, condensation or other damage due to the failure of the owner to maintain adequate ventilation or drainage.

(d) Any loss or damage which the owner has not taken timely action to minimize.

(e) Any defect in, or any defect caused by, materials or work supplied by anyone other than the builder, or any employee, agent or subcontractor of the builder.

(f) Normal wear and tear or normal deterioration.

(g) Loss or damage which does not constitute a defect in the construction of the home by the builder, or any employee, agent or subcontractor of the builder.

(h) Loss or damage resulting from war, accident, riot and civil commotion, water escape, falling objects, aircraft, vehicles, acts of God, lightning, windstorm, hail, flood, mud slide, earthquake, volcanic eruption, wind driven water and changes in the level of the underground water table which are not reasonably foreseeable.

(i) Insect damage and rotting of any kind.

(j) Mold or mold damage, except in cases where the builder's negligence was a proximate or contributing cause of the mold or mold damage.

(k) Any condition which does not result in actual physical damage to the home.

(*l*) Failure of the builder to complete construction of the home.

(m) Any defect not reported in writing by registered or certified mail to the builder or insurance company, as appropriate, prior to the expiration of the period of coverage of that defect plus thirty (30) days.

(n) Consequential damages.

(o) Any loss or damage to a home caused by soil conditions or soil movement if the home is constructed on land owned by the initial purchaser and the builder obtains a written waiver from the initial purchaser for any loss or damage caused by soil conditions or soil movement.

(p) Any defect in an electrical, plumbing, heating, air conditioning or similar fixture not manufactured by the builder for which the manufacturer provides a warranty regardless of duration.

(3) The provisions of this section establish minimum required warranties and shall not be waived by the owner or reduced by the builder, provided the home is a single family dwelling to be occupied by an owner as his home.

**SOURCES: Laws, 1997, ch. 465, § 3; Laws, 2004, ch. 567, § 1, eff from and after July 1, 2004.**

**Editor's Note —** Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

## JUDICIAL DECISIONS

**1. Builder liable.**

Builder was liable to two owners for defects in a new home based on the contractual warranties and the one-year warranty set forth in Miss. Code Ann. § 83-58-5(1)(a) because the term "additional performance standards" in Miss. Code Ann. § 83-58-3(b) incorporated such matters that were set out in the contract, even though no violations of any building code were found. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140 (Miss. Ct. App. 2004).

## RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-7. Written notice of defect to builder.

Before undertaking any repair himself, except repair to minimize loss or damage as provided in Section 83-58-5(2)(d), or instituting any action under Section 83-58-17, the owner shall give the builder written notice within ninety (90) days after knowledge of the defect by registered or certified mail, advising him of the defects and giving the builder a reasonable opportunity to repair the defect. The builder shall give the owner written notice of the requirements of this chapter at the time of closing. If the builder does not provide such notice, the warranties provided in this chapter shall be extended for a period of time equal to the time between the warranty commencement date and date notice was given.

**SOURCES: Laws, 1997, ch. 465, § 4; Laws, 2004, ch. 567, § 2, eff from and after July 1, 2004.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

### JUDICIAL DECISIONS

**1. Notice given.**
Builder was liable for damages resulting from a breach of warranty with regards to the construction of a new house because two owners complied with the Mississippi New Home Warranty Act, Miss. Code Ann. §§ 83-58-1 through 83-58-17, when they only filed suit after the builder failed to respond to their notice regarding many defects in the residence. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140 (Miss. Ct. App. 2004).

### RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-9. Commencement of warranty action.

Any action to enforce any warranty provided in this chapter shall commence thirty (30) days after the expiration of the appropriate time period provided.

**SOURCES: Laws, 1997, ch. 465, § 5, eff from and after July 1, 1997.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

### RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-11. Insurance for warranty allegations.

All or part of the builder's obligation under any warranty required in this chapter may be insured by the builder for the benefit of the purchaser through an insurance company authorized to transact business in this state.

**SOURCES: Laws, 1997, ch. 465, § 6, eff from and after July 1, 1997.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

### RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-13. Transfer of warranties.

Any warranty imposed under the provisions of this chapter and any insurance benefit shall automatically transfer, without charge, to a subsequent owner who acquires title to a home. Any transfer of the home shall not extend the duration of any warranty or insurance coverage.

**SOURCES: Laws, 1997, ch. 465, § 7, eff from and after July 1, 1997.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

### RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-15. Damages; arbitration of claims.

The damages with respect to a single defect shall not exceed the reasonable cost of repair or replacement necessary to cure the defect, and damages with respect to all defects in the home shall not exceed the original purchase price of the home.

The parties may provide for the arbitration of any claim in dispute. Any arbitration may be binding only to the extent provided by law.

**SOURCES: Laws, 1997, ch. 465, § 8, eff from and after July 1, 1997.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:

"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

## JUDICIAL DECISIONS

**1. Damages upheld.**

Damages awarded in a case alleging breach of warranty, a breach of contract, and a breach of the implied duty of reasonably skilled workmanship in a construction contract were upheld on review because they did not exceed the amount of the purchase price, the "cost rule" method was appropriately used calculate the amount required to fix the defects in a new home, the award did not result in economic waste, and the amount awarded was not unreasonable or outrageous. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140 (Miss. Ct. App. 2004).

## RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Recovery of punitive damages for breach of building or construction contract. 40 A.L.R.4th 110.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

## § 83-58-17. Statutory remedy for damages arising from violations of home warranty law; common law remedies.

(1) If a builder violates any of the provisions of this chapter by failing to perform as required by the warranties provided in this chapter, any affected owner shall have a cause of action against the builder for actual damages, including attorney fees and court cost, arising out of the violations.

(2) Nothing in this chapter shall prevent the owner from filing a cause of action based on breach of contract and remedies attendant to such cause of action.

(3) If the owner files a civil action without first complying with the provisions of this chapter, the court shall dismiss the action without prejudice, and the action may not be refiled until the claimant has complied with the notice requirements of this chapter.

**SOURCES: Laws, 1997, ch. 465, § 9; Laws, 2004, ch. 567, § 3, eff from and after July 1, 2004.**

**Editor's Note** — Laws of 1997, ch. 465, § 10 provides that:

"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

## RESEARCH REFERENCES

**ALR.** Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

**Am Jur.** 77 Am. Jur. 2d, Vendor and Purchaser § 283.

# CHAPTER 59

## Business Transacted With Producer Controlled Insurer Act

Sec.
83-59-1. Short title.
83-59-3. Definitions.
83-59-5. Applicability to licensed insurers; effect of, and upon, other laws governing insurance holding companies.
83-59-7. When applicable; minimum requirements for contracts between controlled insurer and controlling producer; audits and reports.
83-59-9. Notification to insured of control relationship.
83-59-11. Enforcement; noncompliance; penalties.

## § 83-59-1. Short title.

This chapter may be cited as the "Business Transacted with Producer Controlled Insurer Act."

**SOURCES: Laws, 1992, ch. 449, § 1, eff from and after July 1, 1992.**

### RESEARCH REFERENCES

**ALR.** Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 161.

## § 83-59-3. Definitions.

As used in this chapter:

(a) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners (NAIC).

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Control" or "controlled" has the meaning ascribed in Section 83-6-1.

(d) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

(e) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(f) "Licensed insurer" or "insurer" means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following, inter alia, are not licensed insurers for the purposes of this chapter:

(i) All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, Public Law No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C.S. Section 3901 et seq. (1982 & Supp. 1986) and the State Risk Retention Act in Section 83-55-1 et seq.;

(ii) All residual market pools and joint underwriting authorities or associations;

(iii) All captive insurers that are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates; and

(iv) All insurers that are insurance companies owned by another organization whose property or casualty insurance policies are written only in conjunction with consumer loan contracts.

(g) "Producer" means an insurance broker or brokers or any other person, firm, association or corporation when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

**SOURCES: Laws, 1992, ch. 449, § 2, eff from and after July 1, 1992.**

**Cross References —** Application of chapter to licensed insurers as defined in this section, see § 83-59-5.

**Federal Aspects —** Superfund Amendments Reauthorization Act of 1986, see 42 USCS §§ 9601 et seq.

## § 83-59-5. Applicability to licensed insurers; effect of, and upon, other laws governing insurance holding companies.

This chapter shall apply to licensed insurers as defined in Section 83-59-3, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All laws governing insurance holding companies to the extent they are not superseded by this chapter shall continue to apply to all parties within holding company systems subject to this chapter.

**SOURCES: Laws, 1992, ch. 449, § 3, eff from and after July 1, 1992.**

## § 83-59-7. When applicable; minimum requirements for contracts between controlled insurer and controlling producer; audits and reports.

(1) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding subsection (1) of this section, this section shall not apply if:

(a) The controlling producer:

(i) Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(ii) Accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

(b) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer or a producer that is a subsidiary of the controlled insurer.

(3) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, and the contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(b) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract;

(d) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(f) The contract shall not be assigned in whole or in part by the controlling producer;

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(h) The rates and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph (g) of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits and similar quality of business;

(i) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified in accordance with subsection (4) of this section;

(j) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(k) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts in accordance with obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(4) Every controlled insurer shall have an Audit Committee of the Board of Directors composed of independent directors. The Audit Committee shall annually meet with management, the insurer's independent certified public accountants and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(a) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the producer; and

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

**SOURCES: Laws, 1992, ch. 449, § 4, eff from and after July 1, 1992.**

**Editor's Note** — Laws of 1992, ch. 449, § 7, effective from and after July 1, 1992, provides as follows:

"SECTION 7. Controlled insurers and controlling producers who are not in compliance with Section 83-59-7 on July 1, 1992, shall have sixty (60) days to come into compliance and shall comply with Section 83-59-9 beginning with all policies written or renewed on or after September 1, 1992."

## § 83-59-9. Notification to insured of control relationship.

The producer, before the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controller insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

**SOURCES: Laws, 1992, ch. 449, § 5, eff from and after July 1, 1992.**

**Editor's Note** — Laws of 1992, ch. 449, § 7, effective from and after July 1, 1992, provides as follows:

"SECTION 7. Controlled insurers and controlling producers who are not in compliance with Section 83-59-7 on July 1, 1992, shall have sixty (60) days to come into compliance and shall comply with Section 83-59-9 beginning with all policies written or renewed on or after September 1, 1992."

### RESEARCH REFERENCES

**ALR.** Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 161.

## § 83-59-11. Enforcement; noncompliance; penalties.

(1)(a) If the commissioner believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer; and

(b) If it was found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered in accordance with the Insurers Rehabilitation and Liquidation Act in Section 83-24-1 et seq. and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance laws.

(4) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

**SOURCES: Laws, 1992, ch. 449, § 6, eff from and after July 1, 1992.**

## RESEARCH REFERENCES

**ALR.** Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

**Am Jur.** 43 Am. Jur. 2d, Insurance § 161.

## CHAPTER 61

## Voluntary Basic Health Insurance Coverage Law

Sec.
83-61-1. Short title.
83-61-3. Definitions.
83-61-5. Promulgation of rules and regulations.
83-61-7. Eligibility.
83-61-9. Participation voluntary.
83-61-11. Exemption from mandated benefits and premium tax.
83-61-13. Written disclosure by the carrier; written statement by eligible individual; services and costs information.
83-61-15. Advisory committee; membership.
83-61-17. Filing of rates.
83-61-19. Minimum loss ratio.

### § 83-61-1. Short title.

This chapter shall be known and may be cited as the "Voluntary Basic Health Insurance Coverage Law."

**SOURCES: Laws, 1992, ch. 578, § 1; reenacted without change, Laws, 1994, ch. 620, § 1, eff from and after July 1, 1994.**

**Editor's Note —** Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

### § 83-61-3. Definitions.

As used in this chapter the following words and phrases shall have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Carrier" means any insurance company, health maintenance association or hospital, medical or surgical services association that is authorized by the State of Mississippi to write accident and health insurance policies and contracts.

(b) "Program" means the Voluntary Basic Health Insurance Coverage Program.

(c) "Provider" means any provider of medical services as defined in the contract of insurance coverage.

(d) "Approved carrier" means any insurance company, health maintenance association or hospital, medical or surgical services association that meets the criteria established by this chapter to participate in the Voluntary Basic Health Insurance Coverage Program.

**SOURCES: Laws, 1992, ch. 578, § 2; reenacted without change, Laws, 1994, ch. 620, § 2, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

## § 83-61-5. Promulgation of rules and regulations.

The Commissioner of Insurance is directed to promulgate rules and regulations to establish procedures for implementation of the provisions of this chapter and penalties for noncompliance.

**SOURCES: Laws, 1992, ch. 578, § 3; reenacted without change, Laws, 1994, ch. 620, § 3, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

## § 83-61-7. Eligibility.

(1) To be eligible for insurance coverage under the program, an individual shall provide evidence to the approved carrier that he or she:

(a) Is under sixty-five (65) years of age;

(b) Is acceptable to the approved carrier; and

(c) Has been without private health insurance coverage for the twelve (12) months immediately preceding application to the program, or that his or her family income does not exceed one hundred fifty percent (150%) of the federal poverty level.

(2) No person who is covered under the program and terminates the coverage is again eligible for coverage unless twelve (12) months have elapsed since the person's latest termination.

**SOURCES: Laws, 1992, ch. 578, § 4; reenacted without change, Laws, 1994, ch. 620, § 4, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of , 1992, ch. 578, § 13.

**Cross References** — Required certification by individual of eligibility, see § 83-61-13.

## § 83-61-9. Participation voluntary.

Participation by carriers and providers in policy authorization by this chapter shall be voluntary.

**SOURCES: Laws, 1992, ch. 578, § 5; reenacted without change, Laws, 1994, ch. 620, § 5, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

### § 83-61-11. Exemption from mandated benefits and premium tax.

Contracts of insurance coverage offered by approved carriers that are approved by the Commissioner of Insurance shall be exempt from all state mandated benefits and from the premium tax required in Sections 27-15-103 and 27-15-109.

**SOURCES: Laws, 1992, ch. 578, § 6; reenacted without change, Laws, 1994, ch. 620, § 6, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

**Cross References** — Premium taxes on foreign insurance companies, see § 27-15-103.

Premium taxes on domestic insurance companies, see § 27-15-109.

### § 83-61-13. Written disclosure by the carrier; written statement by eligible individual; services and costs information.

(1) Upon offering coverage under a minimum benefits or basic coverage contract issued in accordance with this chapter, the approved carrier shall provide the eligible individual with a written disclosure containing at least the following:

(a) An explanation that this is a minimum benefits or basic insurance coverage contract and that benefits otherwise mandated by state law are not covered in the minimum benefits contracts;

(b) An explanation of the benefits mandated by state law;

(c) An explanation of the cost control features of the minimum benefits or basic coverage contract; and

(d) A list of applicable addresses and telephone numbers for use by the eligible individual to obtain information on and authorization for participation in the program.

(2) Before issuing a minimum benefits or basic insurance coverage contract in accordance with this chapter, the approved carrier shall obtain from the eligible individual a signed written statement in which the individual:

(a) Certifies his or her eligibility for coverage under a minimum benefits or basic coverage contract in accordance with Section 83-61-7;

(b) Acknowledges the limited benefits provided under the basic coverage insurance contract.

(3) The State Health Department shall furnish information to approved carriers concerning the services, and the costs of such services, if any, available from the county and state health departments, and such information shall be included in contracts of insurance coverage.

(4) The carriers shall furnish information to their policyholders concerning the federal government's earned income credit for health insurance, and such information shall be included in contracts of insurance coverage issued under this chapter.

**SOURCES: Laws, 1992, ch. 578, § 7; reenacted without change, Laws, 1994, ch. 620, § 7, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

## § 83-61-15. Advisory committee; membership.

The Commissioner of Insurance may appoint an advisory committee, engage consultants or participate in grant programs to study and recommend the details of the program. The advisory committee shall be composed of the following: one (1) physician, one (1) hospital representative, one (1) small business representative, one (1) domestic insurer, one (1) member of the Health Insurance Agents Association, and one (1) nonprofit insurer. One (1) representative of the Department of Insurance shall serve as an ex officio member of the advisory committee. The advisory committee shall serve at the will and pleasure of the Commissioner of Insurance.

**SOURCES: Laws, 1992, ch. 578, § 8; reenacted without change, Laws, 1994, ch. 620, § 8, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

## § 83-61-17. Filing of rates.

The Commissioner of Insurance may require carriers to file rates for informational purposes. Nothing in this chapter shall be construed to require the commissioner's approval before using such rates.

**SOURCES: Laws, 1992, ch. 578, § 9; reenacted without change, Laws, 1994, ch. 620, § 9, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

## § 83-61-19. Minimum loss ratio.

The Commissioner of Insurance may require a minimum loss ratio that carriers must meet in order to participate in the program.

**SOURCES: Laws, 1992, ch. 578, § 10; reenacted without change, Laws, 1994, ch. 620, § 10, eff from and after July 1, 1994.**

**Editor's Note** — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

# CHAPTER 62

## Health Savings Accounts

Sec.
83-62-1. Short title.
83-62-3. Definitions.
83-62-5. Contributions to health savings account; exemption from taxable gross income.
83-62-7. Purposes for which trustee may utilize funds.
83-62-9. Withdrawal of money; disbursement of account assets pursuant to a filing for protection under Bankruptcy Code; transfer of interest in account to spouse under divorce or separation agreement; distribution upon death of eligible individual; transfer upon change of employment.

### § 83-62-1. Short title.

This chapter shall be known and may be cited as the "Health Savings Accounts Act."

**SOURCES: Laws, 2005, ch. 484, § 1, eff from and after Jan. 1, 2005.**

### § 83-62-3. Definitions.

As used in this chapter:

(a) "Eligible individual" means the individual taxpayer, including employees of an employer who contributes to health savings accounts on the employees' behalf, who:

(i) Is covered by a high deductible health plan individually or with his or her dependents as defined in this chapter;

(ii) Is not covered under any health plan that is not a high deductible health plan, except for coverage for accidents, disability, dental care, vision care, long-term care, workers' compensation insurance, insurance for a specified disease or illness, insurance paying a fixed amount per day per hospitalization and coverage for tort liabilities or liabilities relating to ownership or use of property; and

(iii) Establishes, or on whose behalf is established, a health savings account.

(b) "Deductible" means the total deductible for an eligible individual and all the dependents of that eligible individual for a calendar year.

(c) "Dependent" means the spouse or child of the eligible individual as defined in Section 152 of the Internal Revenue Code subject to any additional modifications imposed by Section 223(d) (2) of the Internal Revenue Code.

(d) "Qualified medical expense" means an expense paid by the taxpayer for medical care described in Section 213(d) of the Internal Revenue Code.

(e) "High deductible health plan" means a health plan with:

(i) In the case of self-only coverage, an annual deductible which is not less than One Thousand Dollars ($1,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Five Thousand One Hundred Dollars ($5,100.00).

(ii) In the case of family coverage, an annual deductible of not less than Two Thousand Dollars ($2,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Ten Thousand Two Hundred Dollars ($10,200.00).

(iii) The minimum annual deductible amounts and maximum annual out-of-pocket expense limits may be adjusted each year according to a cost-of-living adjustment as determined under Section 223(g) of the Internal Revenue Code.

(iv) A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care, or in the case of network plans, for having limits for out-of-pocket expenses or annual deductibles for services provided outside the network that exceed the limitations in this section.

(f) "Health savings account" or "account" means a trust or custodian established in this state pursuant to a health savings account program exclusively to pay the qualified medical expenses of an eligible individual or his or her dependents, but only if the written governing instrument creating the account meets the following requirements:

(i) Except in the case of a rollover contribution, no contribution will be accepted unless it is in cash; or, to the extent such contribution, when added to the previous contributions to the account for the calendar year, exceeds one hundred percent (100%) of the eligible individual's deductible or Two Thousand Six Hundred Fifty Dollars ($2,650.00) for an individual or Five Thousand Two Hundred Fifty Dollars ($5,250.00) per family, whichever is lower;

(ii) The trustee or custodian is a bank, an insurance company or another person approved by the United States Department of Treasury and the Commissioner of Insurance;

(iii) No part of the trust assets will be invested in life insurance contracts;

(iv) The assets of the account will not be commingled with other property except as allowed for under Individual Retirement Accounts; and

(v) The eligible individual's interest in the account is nonforfeitable.

The maximum dollar amounts in this paragraph may be adjusted each year according to a cost-of-living adjustment as determined under Section 223(g) of the Internal Revenue Code.

Eligible individuals who have attained age fifty-five (55) before the end of the year may make additional catch-up contributions into the account in the amount determined in accordance with the following table:

| | |
|---|---|
| 2005 | $ 600.00 |
| 2006 | $ 700.00 |
| 2007 | $ 800.00 |

| | |
|---|---|
| 2008 | $ 900.00 |
| 2009 and thereafter | $1,000.00 |

(g) "Health savings account program" or "program" means a program that includes all of the following:

(i) The purchase by an eligible individual or by an employer of a high deductible health plan; and

(ii) The contribution into a health savings account by or on behalf of an eligible individual or on behalf of an employee by his or her employer. The total annual contribution may not exceed the amount of the plan's higher deductible or the amounts listed herein.

**SOURCES: Laws, 2005, ch. 484, § 2, eff from and after Jan. 1, 2005.**

**Federal Aspects** — Sections 152, 213(d) and 223(d)(2) and (g) of the Internal Revenue Code, see 26 USCS §§ 152, 213(d) and 223(d)(2) and (g), respectively.

## § 83-62-5. Contributions to health savings account; exemption from taxable gross income.

(1) For taxable years beginning after January 1, 2005, contributions may be made into a health savings account by or on behalf of a resident of Mississippi pursuant to Section 83-62-3(f).

(2) Except as provided in Section 83-62-9, or except as otherwise provided by law, the principal contributed to and the interest earned on a health savings account and money reimbursed to an eligible individual or an employee for qualified medical expenses shall be excluded from the taxable gross income of the account holder under Section 27-7-15.

**SOURCES: Laws, 2005, ch. 484, § 3, eff from and after Jan. 1, 2005.**

## § 83-62-7. Purposes for which trustee may utilize funds.

The trustee or custodian shall utilize the funds held in a health savings account solely for the purpose of:

(a) Paying the qualified medical expenses of the eligible individual or his or her dependents;

(b) Purchasing a health coverage policy certificate, or contract, for an eligible individual who is receiving unemployment compensation, is exercising continuation privileges under federal law or is purchasing a long-term care insurance contract; or

(c) Paying for health insurance other than a Medicare supplemental policy for those who are Medicare eligible. Funds held in a health savings account shall not be used to cover expenses of the eligible individual or his or her dependents that are otherwise covered, including, but not limited to, medical expense covered pursuant to an automobile insurance policy, workers' compensation insurance policy or self-insured plan or another employer-funded health coverage policy, certificate or contract.

**SOURCES: Laws, 2005, ch. 484, § 4, eff from and after Jan. 1, 2005.**

### § 83-62-9. Withdrawal of money; disbursement of account assets pursuant to a filing for protection under Bankruptcy Code; transfer of interest in account to spouse under divorce or separation agreement; distribution upon death of eligible individual; transfer upon change of employment.

(1) Notwithstanding subsection (3), (4), (5) or (6) of this section, an eligible individual may withdraw money from his or her health savings account for any purpose other than a purpose described in Section 83-62-7.

(2) Subject to subsection (3) of this section, if the eligible individual withdraws money for any purpose other than a purpose described in Section 83-62-7 at any other time, all of the following apply:

(a) The amount of the withdrawal is considered taxable gross income of the account holder under Section 27-7-15 in the tax year of the withdrawal.

(b) Interest earned on the account during the tax year in which a withdrawal under this subsection is made is considered taxable gross income of the account holder under Section 27-7-15.

(3) The amount of disbursement of any assets of a health savings account pursuant to a filing for protection under Title 11 of the United States Code, 11 USCS 101 et seq., by an eligible individual or person for whose benefit the account was established is not considered a withdrawal for purposes of this section. The amount of a disbursement is not considered taxable gross income of the account holder under Section 27-7-15 and subsection (2) of this section does not apply.

(4) The transfer of an eligible individual's interest in a health savings account to an eligible individual's spouse or former spouse under a divorce or separation instrument shall not be considered a taxable transfer made by such eligible individual, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the eligible individual.

(5) Upon the death of the eligible individual, the trustee or custodian shall distribute the principal and accumulated interest of the health savings account to the estate of the deceased.

(6) If an employee becomes employed with a different employer that participates in a health savings account program, the employee may transfer his or her health savings account to that new employer's trustee or custodian or to an individually purchased account program.

**SOURCES: Laws, 2005, ch. 484, § 5, eff from and after Jan. 1, 2005.**

## CHAPTER 63

## Small Employer Health Benefit Plans

SEC.
83-63-1. Application of chapter.
83-63-3. Definitions.
83-63-5. Limitation on establishment of classes of business by small employer carriers.
83-63-6. Requirements for small employer carriers.
83-63-7. Procedures for premium rates and restrictions on premium rate increases; authority to establish regulations; restrictions on transfers or offers to transfer small employer into or out of class of business; suspension of application of index rate provision.
83-63-9. Disclosure requirements for solicitation and sales material for sale of health benefit plan; maintenance of description of rating practices and renewal underwriting practices; actuarial certification requirements; access to information and documentation by commissioner; confidentiality of information.
83-63-11. Renewal of health benefit plan at option of small employer; exceptions; right of carrier to cease to renew all plans under a class of business; restrictions; application of section to carrier operating in single geographic area.

### § 83-63-1. Application of chapter.

(1) This chapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

(2) This chapter shall not apply to an employer whose only role is collecting through payroll deduction the premiums of individual policies on behalf of employees.

**SOURCES: Laws, 1994, ch. 302, § 1, eff from and after January 1, 1995.**

**Federal Aspects —** Sections 106, 125, and 162 of the United States Internal Code, see 26 USCS §§ 106, 125, and 162.

### § 83-63-3. Definitions.

For purposes of this chapter, the following terms are defined as follows:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with Section 83-63-7, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Base premium rate" means for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(c) "Carrier" means any entity that provides health insurance in this state such as an insurance company; a prepaid hospital or medical service plan; a nonprofit hospital, medical and surgical service corporation; a health maintenance organization; a fully insured multiple employer welfare arrangement; or any other entity providing a plan of health insurance subject to state insurance regulation.

(d) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, but claim experience, health status and duration of coverage are not case characteristics for the purposes of this chapter.

(e) "Class of business" means all or a separate grouping of small employers established pursuant to Section 83-63-5.

(f) "Commissioner" means the Commissioner of Insurance.

(g) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty-two (32) or more hours. The term includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.

(h) "Established geographic service area" means a geographical area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(i) "Health benefit plan" or "plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, specified disease, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(j) "Index rate" means for each class of business for small employees with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(k) "New business premium rate" means for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(*l*) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(m) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one (1) employer.

(n) "Small employer carrier" means any carrier which offers health benefit plans covering eligible employees of one or more small employers in this state.

**SOURCES: Laws, 1994, ch. 302, § 2; Laws, 1997, ch. 341, § 1, eff from and after passage (approved from and after March 17, 1997).**

## § 83-63-5. Limitation on establishment of classes of business by small employer carriers.

(1) A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage through an association with membership of not less than twenty-five (25) small employers which has been formed for purposes other than obtaining insurance.

(2) A small employer carrier may establish up to nine (9) separate classes of business under subsection (1).

(3) The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

**SOURCES: Laws, 1994, ch. 302, § 3, eff from and after January 1, 1995.**

**Cross References** — "Class of business" as meaning all or a separate grouping of small employers established pursuant to this section, see § 83-63-3.

## § 83-63-6. Requirements for small employer carriers.

Any small employer carrier shall issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter. However, no carrier is required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

**SOURCES: Laws, 1997, ch. 341, § 2, eff from and after passage (approved March 17, 1997).**

## § 83-63-7. Procedures for premium rates and restrictions on premium rate increases; authority to establish regulations; restrictions on transfers or offers to transfer small employer into or out of class of business; suspension of application of index rate provision.

(1) Premium rates for health benefit plans subject to this chapter shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate;

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) In the case of health benefit plans issued prior to January 1, 1995, a premium rate for a rating period may exceed the ranges set forth in paragraphs (a) and (b) of this subsection until January 1, 1996. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate;

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business; and

(iii) Any adjustment needed to bring the premium rate of a small employer to the base premium rate for that class of business.

(f) If an employer not meeting the definition of "small employer" on the date of issue or last renewal of its plan falls within such definition on a subsequent renewal date, and its premium rate is less than the base premium rate for the small employer class of business into which it is assigned, the employer's rate shall be the base premium rate for that class of business.

(g) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(h) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including:

(i) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribing the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a

finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

**SOURCES: Laws, 1994, ch. 302, § 4, eff from and after January 1, 1995.**

**Cross References** — "Actuarial certification" as meaning statement that small employer carrier is in compliance with this section, see § 83-63-3.

## § 83-63-9. Disclosure requirements for solicitation and sales material for sale of health benefit plan; maintenance of description of rating practices and renewal underwriting practices; actuarial certification requirements; access to information and documentation by commissioner; confidentiality of information.

(1) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(c) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;

(d) The provisions relating to renewability of policies and contracts; and

(e) The provisions relating to any pre-existing condition provision.

(2) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(3) Each small employer carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(4) A small employer carrier shall make the information and documentation described in subsection (2) available to the commissioner upon request. Except in cases of violations of this chapter, the information shall be consid-

ered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

**SOURCES: Laws, 1994, ch. 302, § 5, eff from and after January 1, 1995.**

## § 83-63-11. Renewal of health benefit plan at option of small employer; exceptions; right of carrier to cease to renew all plans under a class of business; restrictions; application of section to carrier operating in single geographic area.

(1) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or misrepresentation of the small employer, or with respect to coverage of individual insureds, the insureds or their representatives;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) Repeated misuse of a provider network provision; or

(f) The commissioner finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the Commissioner of Insurance in each state in which an affected insured individual is known to reside at least one hundred eighty (180) days prior to termination of coverage. A carrier which exercises its rights to cease to renew all plans in a class of business shall not:

(a) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the Commissioner of Insurance; or

(b) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

(3) In the case of a small employer carrier doing business in one (1) established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in such service area.

**SOURCES: Laws, 1994, ch. 302, § 6, eff from and after January 1, 1995.**

## RESEARCH REFERENCES

**Am Jur.** 43 Am. Jur. 2d, Insurance §§ 388-391.

# CHAPTER 64

## Health Discount Plans

| Sec. | |
|---|---|
| 83-64-1. | Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability [Repealed effective July 1, 2013]. |

### § 83-64-1. Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability [Repealed effective July 1, 2013].

(1) "Health discount plan" means a card, program, device, arrangement, contract or mechanism that purports to offer discounts or access to discounts on health care services or supplies that is not insurance or that does not provide coverage for services or benefits regulated under Section 83-9-1 et seq.

(2) A person may not sell, market, promote, advertise or otherwise distribute a health discount plan unless:

(a) Each advertisement, policy, document, information, statement or other communication regarding the health discount plan and the plan itself contain a statement, in bold and prominent type, that the health discount plan is not insurance;

(b) The discounts offered under the health discount plan are specifically authorized by a contract with each provider of the services or supplies listed in conjunction with the plan;

(c) The health discount plan states the name, address and telephone number of the administrator of the plan;

(d) The person makes readily available to the consumer a complete, accurate and up-to-date list of providers participating in the plan that offers discounted health care services or supplies in the consumer's local area and the discounts offered by the providers;

(e) The person provides the consumer the right to cancel the health discount plan within thirty (30) days after purchase of the plan; and

(f) The person provides the consumer with a full refund of all payments made, except for a nominal processing fee, within thirty (30) days after notification of cancellation of the plan under paragraph (e) of this subsection.

(3) The Commissioner of Insurance may adopt regulations to implement this section and to establish additional requirements intended to prohibit unfair or deceptive practices relating to health discount plans.

(4) Rebates and discounts for health discount plans shall not apply to manufacturers of pharmaceuticals or supplies. This section shall not apply to the Division of Medicaid and shall not apply to pharmaceutical manufacturer discount cards.

(5) This section shall stand repealed on July 1, 2013.

**SOURCES: Laws, 2007, ch. 553, § 7; Laws, 2010, ch. 419, § 1, eff from and after July 1, 2010.**

**Amendment Notes** — The 2010 amendment substituted “July 1, 2013” for “July 1, 2010” in (5); and made a minor stylistic change.

# CHAPTER 65

## Regulation of Vehicle Service Contracts

Sec.
83-65-101. Purpose.
83-65-103. Definitions.
83-65-105. Issuance, sale, or offer for sale of service contract; authorized providers.
83-65-107. Issuance, sale, or offer for sale of service contract; document filing requirements; rates.
83-65-109. Issuance, sale, or offer for sale of reimbursement insurance policy.
83-65-111. Issuance, sale, or offer for sale of service contract; form and terms of contract.
83-65-113. Use of particular words in names of providers, contracts or literature; false or misleading statements or omissions, etc., by providers; requirement of purchase of vehicle service contract as condition of loan or sale.
83-65-115. Recordkeeping requirements.
83-65-117. Cancellation of reimbursement insurance policy.
83-65-119. Complaint against providers.
83-65-121. Promulgation of regulations.
83-65-123. Application of chapter.
83-65-125. Provider not required to be named insured under reimbursement insurance policy under certain circumstances.

### § 83-65-101. Purpose.

The sole purpose of this chapter is to provide for the regulation of vehicle service contracts. This chapter does not apply to motor vehicle manufacturers' warranties.

**SOURCES: Laws, 1995, ch. 302, § 1, eff from and after passage (approved February 28, 1995).**

### § 83-65-103. Definitions.

For the purposes of this chapter:

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Service contract holder" means a person who purchases or otherwise obtains a vehicle service contract.

(c) "Vehicle service contract" means a contract or agreement that undertakes to perform or provide repair or replacement service, or provide payment for that service, for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear.

(d) "Provider" means a person who issues, makes or provides a vehicle service contract.

(e) "Reimbursement insurance policy" means a policy of insurance providing reimbursement coverage for all services which the provider is legally obligated to provide under the terms of vehicle service contracts issued or sold by the provider.

(f) "Services" means the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear.

**SOURCES: Laws, 1995, ch. 302, § 2, eff from and after passage (approved February 28, 1995).**

### § 83-65-105. Issuance, sale, or offer for sale of service contract; authorized providers.

A vehicle service contract shall not be issued, sold, or offered for sale in this state unless the provider of the vehicle service contract is a named insured under a reimbursement insurance policy issued by an insurer authorized to do business in this state.

**SOURCES: Laws, 1995, ch. 302, § 3, eff from and after passage (approved February 28, 1995).**

**Cross References** — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

### § 83-65-107. Issuance, sale, or offer for sale of service contract; document filing requirements; rates.

A vehicle service contract shall not be issued, sold, or offered for sale in this state unless a true and correct copy of the vehicle service contract and the provider's reimbursement insurance policy and the rates to be charged for the reimbursement insurance policy have been filed by the insurer issuing the reimbursement insurance policy with the commissioner. Rates shall not be excessive, inadequate or unfairly discriminatory.

**SOURCES: Laws, 1995, ch. 302, § 4, eff from and after passage (approved February 28, 1995).**

**Cross References** — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

### § 83-65-109. Issuance, sale, or offer for sale of reimbursement insurance policy.

A reimbursement insurance policy shall not be issued, sold, or offered for sale in this state unless the reimbursement insurance policy conspicuously states that the issuer of the policy shall provide on behalf of the provider all services which the provider is legally obligated to provide according to the provider's contractual obligations under the vehicle service contracts issued or sold by the provider.

**SOURCES: Laws, 1995, ch. 302, § 5, eff from and after passage (approved February 28, 1995).**

**Cross References** — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

## § 83-65-111. Issuance, sale, or offer for sale of service contract; form and terms of contract.

(1) A vehicle service contract shall not be issued, sold, or offered for sale in this state unless the contract conspicuously states that the obligations of the provider to the service contract holder to provide services are guaranteed under a reimbursement insurance policy, and unless the contract conspicuously states the name and address of the issuer of the reimbursement policy.

(2) Every vehicle service contract shall be written in clear, understandable language and shall be printed or typed in easy-to-read type, size and style, and shall not be issued, sold, or offered for sale in this state unless the contract:

(a) Conspicuously states that the services for which the provider is legally obligated to perform to the service contract holder are guaranteed under a reimbursement insurance policy;

(b) Conspicuously states the name and address of the issuer of the reimbursement insurance policy;

(c) Identifies the provider, the seller, and the service contract holder;

(d) Sets forth the total purchase price and the terms under which it is to be paid;

(e) Sets forth the procedure for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours;

(f) Conspicuously states the existence of a deductible amount, if any;

(g) Specifies the merchandise or services, or both, to be provided and any limitations, exceptions or exclusions;

(h) Sets forth the conditions on which the use of non-original manufacturers parts, or substitute service, will be allowed;

(i) Conspicuously sets forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage to the vehicle and the requirement for certain service and maintenance;

(j) Sets forth any terms, restrictions, or conditions governing transferability of the vehicle service contract.

**SOURCES: Laws, 1995, ch. 302, § 6, eff from and after passage (approved February 28, 1995).**

**Cross References** — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

## § 83-65-113. Use of particular words in names of providers, contracts or literature; false or misleading statements or omissions, etc., by providers; requirement of purchase of vehicle service contract as condition of loan or sale.

(1) Unless licensed as an insurance company, a provider shall not use in its name, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation, or any other vehicle service contract provider.

(2) A provider shall not, without the written consent of the purchaser, knowingly charge a purchaser for duplication of coverage or duties required by state or federal law, a warranty expressly issued by a manufacturer or seller of a product or any implied warranty enforceable against the lessor, seller, or manufacturer of a product.

(3) A provider shall not make, permit, or cause any false or misleading statements, either oral or written, in connection with the sale, offer to sell, or advertisement of a vehicle service contract.

(4) A provider shall not permit or cause the omission of any material statement in connection with the sale, offer to sell, or advertisement of a vehicle service contract, which under the circumstances should have been made in order to make the statements that were made not misleading.

(5) A provider shall not make, permit, or cause any false or misleading statements, either oral or written, about the benefits or services available under the vehicle service contract.

(6) A provider shall not make, permit, or cause any statement or practice which has the effect of creating or maintaining a fraud.

(7) A provider is prohibited from making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the vehicle service contract industry or with respect to any provider which is untrue, deceptive, or misleading.

(8) A person such as a bank, savings and loan association, insurance company, lending institution, manufacturer or seller of any product, shall not require the purchase of a vehicle service contract as a condition of a loan or a sale.

(9) A provider is prohibited from making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(10) A provider is prohibited from entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the service contract industry.

(11) A provider is prohibited from knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(12) A provider is prohibited from knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

**SOURCES: Laws, 1995, ch. 302, § 7, eff from and after passage (approved February 28, 1995).**

## § 83-65-115. Recordkeeping requirements.

(1) All providers shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.

(2) A provider's accounts, books, and records shall include:

(a) Copies of all service contracts;

(b) The name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder;

(c) The dates, amounts, and descriptions of all receipts, claims, and expenditures.

(3) A provider shall retain all required accounts, books, and records pertaining to each service contract holder for at least two (2) years after the specified period of coverage has expired. A provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to contract holders in this state.

(4) Providers shall make all accounts, books, and records concerning transactions regulated under this chapter available to the commissioner for the purpose of examination.

**SOURCES: Laws, 1995, ch. 302, § 8, eff from and after passage (approved February 28, 1995).**

## § 83-65-117. Cancellation of reimbursement insurance policy.

(1) The issuer of a reimbursement insurance policy shall not cancel such reimbursement insurance policy unless sixty (60) days written notice of cancellation has been given to the commissioner and to each insured provider, including automobile dealers and third-party administrators.

(2) The cancellation of a reimbursement insurance policy shall not reduce the issuer's responsibility for vehicle service contracts issued by providers prior to the date of cancellation.

**SOURCES: Laws, 1995, ch. 302, § 9, eff from and after passage (approved February 28, 1995).**

## § 83-65-119. Complaint against providers.

(1) The commissioner may receive and process each complaint made against any provider which alleges certain acts or practices which may constitute one or more violations of this chapter. Any member of the public, or any federal, state, or local official, may file a complaint with the commissioner. Complaints may be received from sources outside the State of Mississippi and processed in the same manner as those originating in Mississippi.

(2) All complaints shall be made in writing and shall fully identify the complainant by name and address. If required by the commissioner, complaints shall be made on forms prescribed and provided by the commissioner.

(3) Oral or telephone communications may not be considered or processed as complaints. However, any member of the staff of the commissioner may file a complaint based upon information and belief, in reliance upon oral, telephone, or written communications received by the commissioner.

**SOURCES: Laws, 1995, ch. 302, § 10, eff from and after passage (approved February 28, 1995).**

## § 83-65-121. Promulgation of regulations.

The commissioner may promulgate regulations necessary to effectuate this chapter.

**SOURCES: Laws, 1995, ch. 302, § 11, eff from and after passage (approved February 28, 1995).**

## § 83-65-123. Application of chapter.

If any provision of this chapter or the application thereof to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the chapter or the applicability of such provision to other persons or circumstances shall not be affected.

**SOURCES: Laws, 1995, ch. 302, § 12, eff from and after passage (approved February 28, 1995).**

### § 83-65-125. Provider not required to be named insured under reimbursement insurance policy under certain circumstances.

(1) A provider shall not be required to be a named insured under a reimbursement insurance policy for purposes of issuing, selling or offering for sale a vehicle service contract in this state if the provider complies with the following requirements:

(a) Maintains, or has a parent company maintain, a net worth or stockholders' equity of at least One Hundred Million Dollars ($100,000,000.00);

(b) Upon request, files with the commissioner a true and correct copy of the vehicle service contract;

(c) Upon request, files with the commissioner a copy of the provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission within the preceding calendar year. If the provider or the provider's parent company does not file with the Securities and Exchange Commission, the provider, upon request, shall file with the commissioner a copy of the provider's or the provider's parent company's audited financial statements showing a net worth of the provider or its parent company of at least One Hundred Million Dollars ($100,000,000.00). If the provider's parent company's Form 10-K, Form 20-F or audited financial statements are filed to show that the provider meets the financial requirements of this section, the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state.

(2) If a provider complies with the requirements of subsection (1) the provider may issue, sell or offer for sale in this state vehicle service contracts and such contracts shall not be subject to the requirements of Sections 83-65-105, 83-65-107, 83-65-109 and subsections (2)(a) and (b) of Section 83-65-111.

**SOURCES: Laws, 2011, ch. 401, § 1, eff from and after July 1, 2011.**

**Joint Legislative Committee Note —** Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in (1)(a). The word "company" was inserted between the words "parent" and "maintain" in following excerpt "(a) Maintains, or has a parent maintain..." so the phrase now reads "(a) Maintains, or has a parent company maintain..." The Joint Committee ratified the correction at its July 13, 2011, meeting.

## CHAPTER 67

## Utilization of Modern Systems for Holding and Transferring Securities Without Physical Delivery

Sec.
83-67-1. In general.
83-67-3. Definitions.
83-67-5. Deposit of securities with clearing corporation or Federal Reserve book-entry system; promulgation of rules and regulations.

### § 83-67-1. In general.

The purpose of this chapter is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate regulations of the Commissioner of Insurance.

**SOURCES: Laws, 2001, ch. 412, § 1, eff from and after July 1, 2001.**

**Cross References —** Reserve liabilities and deposit requirements for life insurance companies, see § 83-7-21.

Capital requirements for various classes of domestic insurance companies, see § 83-19-31.

Capital and deposit requirements for admission of foreign insurance companies, see § 83-21-3

### § 83-67-3. Definitions.

As used in this chapter, the term:

(a) "Clearing corporation" means a corporation as defined in Section 75-8-102, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation may include a corporation which is organized or existing under the laws of any foreign country and is legally qualified under such laws to effect transactions in securities by computerized book-entry.

(b) "Direct participant" means a bank or trust company or other institution which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(c) "Federal Reserve book-entry system" means the computerized systems sponsored by the United States Department of the Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in Federal Reserve Banks through banks which are members of the Federal Reserve System or which otherwise have access to such computerized systems.

(d) "Member bank" means a national bank, state bank or trust company which is a member of the Federal Reserve System and through which an insurance company participates in the Federal Reserve book-entry system.

(e) "Securities" means instruments as defined in Section 75-8-102 or as permitted by the insurance laws of the State of Mississippi.

**SOURCES: Laws, 2001, ch. 412, § 2, eff from and after July 1, 2001.**

## § 83-67-5. Deposit of securities with clearing corporation or Federal Reserve book-entry system; promulgation of rules and regulations.

(1) Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the Federal Reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any member bank through which an insurance company holds securities in the Federal Reserve book-entry system, and the records of any custodian banks through which an insurance company holds securities in a clearing corporation shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the Federal Reserve book-entry system without, in either case, physical delivery of certificates representing such securities.

(2) The Commissioner of Insurance is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations and in the Federal Reserve book-entry system.

**SOURCES: Laws, 2001, ch. 412, § 3, eff from and after July 1, 2001.**

# CHAPTER 69

## Interstate Insurance Product Regulation Compact

Sec.
83-69-1. Purposes; definitions; Interstate Insurance Product Regulation Commission creation, organization, meetings, and rulemaking functions; effective date of compact; withdrawal, default and termination; severability and construction; relationship to other laws.

### § 83-69-1. Purposes; definitions; Interstate Insurance Product Regulation Commission creation, organization, meetings, and rulemaking functions; effective date of compact; withdrawal, default and termination; severability and construction; relationship to other laws.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into by this state with any and all states legally joining in accordance with its terms, in the form substantially as follows:

**Article I. Purposes.** — The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;
2. To develop uniform standards for insurance products covered under the Compact;
3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;
4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of Uniform Standards and review of insurance products covered under the Compact;
6. To create the Interstate Insurance Product Regulation Commission; and
7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

**Article II. Definitions.** — For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.
2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Compact.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Noncompacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third Party Filer" means an entity that submits a product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a product line, pursuant to Article VII of this Compact, and shall include all of the product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

**Article III. Establishment of the Commission and Venue. —**

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for product lines, receive and provide prompt review of

products filed therewith, and give approval to those product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

**Article IV. Powers of the Commission.** — The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product

covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an Insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

**Article V. Organization of the Commission. —**

1. Membership, Voting and Bylaws.

a. Each Compacting State shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each member shall be entitled to one (1) vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (⅔) of the members vote in favor thereof.

c. The Commission shall, by a majority of the members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel.

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (⅔) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees.

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission. The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification.

a. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

**Article VI. Meetings and Acts of the Commission. —**

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

**Article VII. Rules and Operating Procedures: Rulemaking Functions of the Commission and Opting Out of Uniform Standards. —**

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this Compact; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

**Article VIII. Commission Records and Enforcement. —**

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Compact, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

**Article IX. Dispute Resolution.** — The Commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two (2) or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

**Article X. Product Filing and Approval. —**

1. Insurers and Third Party Filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this Compact shall be construed to restrict or otherwise prevent an Insurer from filing its product with the insurance department in any State wherein the Insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

3. Any product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

**Article XI. Review of Commission Decisions Regarding Filings. —**

1. Not later than thirty (30) days after the Commission has given notice of a disapproved product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

**Article XII. Finance. —**

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

**Article XIII. Compacting States, Effective Date and Amendment. —**

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective

and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

**Article XIV. Withdrawal, Default and Termination. —**

1. Withdrawal.

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default.

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact.

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one (1) Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

**Article XV. Severability and Construction. —**

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

**Article XVI. Binding Effect of Compact and Other Laws. —**

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state including, but not limited to, maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact.

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

**SOURCES: Laws, 2009, ch. 357, § 1, eff from and after July 1, 2009.**

**Editor's Note —** In May 2006, both threshold goals for making this compact operation were met.

**Cross References —** Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

**Comparable Laws from other States —** Alaska: Alaska Stat. § 21.42 et seq.
Colorado: C.R.S. § 24-60-3001.
Georgia: O.C.G.A. § 33-59A-1.
Hawaii: H.R.S. § 431:30-101 et seq.
Idaho: Idaho Code § 41-5702.
Indiana: Burn's Ind. Code Ann. § 27-8-31-1 et seq.
Iowa: Iowa Code § 505A.1.
Kansas: K.S.A. § 40-5301.
Kentucky: K.R.S. § 304.51-010.
Louisiana: La. R.S. § 22:2381.
Maine: 24-A M.R.S. § 2471 et seq.
Maryland: Md. INSURANCE Code Ann. § 29-101.
Michigan: MCLS § 3.1031.
Minnesota: Minn. Stat. § 60A.99.
Missouri: § 374.352 R.S.Mo.
Nebraska: R.R.S. Neb. § 44-7801.
New Mexico: N.M. Stat. Ann. § 11-19-1.
North Carolina: N.C. Gen. Stat. § 58-91-1 et seq.
Ohio: Page's ORC Ann. § 3915.16
Oklahoma: 36 Okl. St. § 7004.

Pennsylvania: 40 P.S. § 4103.
Rhode Island: R.I. Gen. Laws, § 27-2.5-2.
South Carolina: S.C. Code Ann. § 38-95-10 et seq.
Tennessee: Tenn. Code Ann. § 56-58-102.
Texas: Tex. Ins. Code § 5001.002.
Utah: Utah Code Ann. § 31A-39-101.
Vermont: 8 V.S.A. § 8500 et seq.
Virginia: Va. Code Ann. §§ 38.2-6200 et seq.
Washington: Rev. Code Wash. (ARCW) § 48.130 et seq.
West Virginia: W.Va. Code § 33-47-1 et seq.
Wisconsin: Wis. Stat. § 601.58.
Wyoming: Wyo. Stat. § 26-15-201.

# CHAPTER 71

## Unfair Discrimination Against Subjects of Abuse in Health, Life, and Disability Income Insurance

Discrimination Against Subjects of Abuse in Health Insurance .......... 83-71-1
Discrimination Against Subjects of Abuse in Life Insurance ............. 83-71-51
Discrimination Against Subjects of Abuse in Disability Income Insurance 83-7-101

## DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH INSURANCE

Sec.
83-71-1. Purpose.
83-71-3. Applicability of Sections 83-71-1 through 83-71-15 to health carriers and insurance professionals issuing or renewing health insurance policies or certificates of health insurance in Mississippi.
83-71-5. Definitions.
83-71-7. Unfair discriminatory acts; health insurance.
83-71-9. Health carrier or insurance professional taking adverse action on the basis of a medical condition health carrier or insurance professional knows is abuse-related required to provide explanation for action.
83-71-11. Health carriers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.
83-71-13. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-1 through 83-71-15.
83-71-15. Applicability of Sections 83-71-1 through 83-71-15 to certain health benefit plans and certain applications for coverage under health benefit plans.

### § 83-71-1. Purpose.

The purpose of Sections 83-71-1 through 83-71-15 is to prohibit unfair discrimination by health carriers and insurance professionals on the basis of abuse status. Nothing in Sections 83-71-1 through 83-71-15 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-1 through 83-71-15.

**SOURCES: Laws, 2010, ch. 455, § 1, effective from and after July 1, 2010.**

### § 83-71-3. Applicability of Sections 83-71-1 through 83-71-15 to health carriers and insurance professionals issuing or renewing health insurance policies or certificates of health insurance in Mississippi.

Sections 83-71-1 through 83-71-15 apply to all health carriers and insurance professionals involved in issuing or renewing in this state a policy or certificate of health insurance.

**SOURCES: Laws, 2010, ch. 455, § 2, eff from and after July 1, 2010.**

## § 83-71-5. Definitions.

As used in Sections 83-71-1 through 83-71-15, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person or minor child without proper authority, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, a person's medical condition that the carrier knows or has reason to know is abuse-related, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Health benefit plan" or "plan" means a policy, contract, certificate or agreement offered by a carrier or insurance professional to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health benefit plan includes accident only, credit health, dental, vision, Medicare supplement or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis. Health benefit plan does not include workers' compensation or similar insurance.

(g) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health services.

(h) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(i) "Insured" means a party named on a health benefit plan as the person with legal rights to the benefits provided by the health benefit plan. For group plans, "insured" includes a person who is a beneficiary covered by a group health benefit plan.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse, or protection, court-ordered protection or shelter from abuse.

**SOURCES: Laws, 2010, ch. 455, § 3, eff from and after July 1, 2010.**

## § 83-71-7. Unfair discriminatory acts; health insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health benefit plan or restrict or exclude health benefit plan coverage or add a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status; or

(b) Exclude or limit coverage for losses or deny a claim incurred by an insured on the basis of the insured's abuse status;

(2) When the health carrier or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of the confidential abuse information by a person employed by or contracting with a health carrier or insurance professional for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law; or

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-1 through 83-71-15 in all respects and to be subject to the enforcement of Sections 83-71-1 through 83-71-15 by the courts of this state for the benefit of the applicant or the insured and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the health carrier or insurance professional;

(iii) Medical or claims personnel contracting with the health carrier or insurance professional, only where necessary to process an application or perform the health carrier's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the health carrier or insurance professional that have service agreements with the health carrier or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the health carrier or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the health carrier or insurance professional effectively, if the health carrier or insurance professional notifies the attorney of its obligations under Sections 83-71-1 through 83-71-15 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the health carrier or insurance professional;

(g) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information relating to acts of abuse or an applicant's or insured's abuse status or make use of that information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a subject of abuse.

(4) It is unfairly discriminatory to terminate group coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from or lost custody of the subject of abuse or the abuser's coverage has terminated voluntarily or involuntarily. Nothing in this subsection prohibits the health carrier or insurance professional from requiring the subject of abuse to pay the full premium for coverage under the health plan or from requiring as a condition of coverage that the subject of abuse reside or work within its service area, if the requirements are applied to all insureds of the health carrier or insurance professional. The health carrier or insurance professional may terminate group coverage after the continuation coverage required by this subsection has been in force for eighteen (18) months, if it offers conversion to an equivalent individual plan. The continuation coverage required by this section shall be satisfied by coverage required under Public Law 99-272, the Consolidated Omnibus Budget Reconciliation

Act (COBRA) of 1985, provided to a subject of abuse and is not intended to be in addition to coverage provided under COBRA.

(5) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(6) Subsection (3) of this section does not prohibit a health carrier or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-1 through 83-71-15 and other applicable law.

**SOURCES: Laws, 2010, ch. 455, § 4, eff from and after July 1, 2010.**

**Federal Aspects —** The Consolidated Omnibus Budget Reconciliation Act is codified as 29 USCS §§ 1161 et seq.

## § 83-71-9. Health carrier or insurance professional taking adverse action on the basis of a medical condition health carrier or insurance professional knows is abuse-related required to provide explanation for action.

A health carrier or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the health carrier or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable plan provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

(d) Except for claim actions, is based on a determination, made in conformance with sound actuarial principles and supported by reasonable statistical evidence, that there is a correlation between the medical condition and a material increase in insurance risk.

**SOURCES: Laws, 2010, ch. 455, § 5, eff from and after July 1, 2010.**

### § 83-71-11. Health carriers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Health carriers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-1 through 83-71-15 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

**SOURCES: Laws, 2010, ch. 455, § 6, eff from and after July 1, 2010.**

### § 83-71-13. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-1 through 83-71-15.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-1 through 83-71-15 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-1 through 83-71-15 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

**SOURCES: Laws, 2010, ch. 455, § 7, eff from and after July 1, 2010.**

### § 83-71-15. Applicability of Sections 83-71-1 through 83-71-15 to certain health benefit plans and certain applications for coverage under health benefit plans.

Sections 83-71-1 through 83-71-15 apply to every health benefit plan or plan that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a health benefit plan or plan.

**SOURCES: Laws, 2010, ch. 455, § 8, eff from and after July 1, 2010.**

## DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE

Sec.
83-71-51. Purpose.
83-71-53. Applicability of Sections 83-71-51 through 83-71-65 to life insurers and insurance professionals issuing or renewing life insurance policies or certificates of life insurance in Mississippi.
83-71-55. Definitions.
83-71-57. Unfair discriminatory acts; life insurance.
83-71-59. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.
83-71-61. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.
83-71-63. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-51 through 83-71-65.
83-71-65. Applicability of Sections 83-71-51 through 83-71-65 to certain policies or certificates of life insurance and certain applications for coverage under a policy or certificate of life insurance.

### § 83-71-51. Purpose.

The purpose of Sections 83-71-51 through 83-71-65 is to prohibit unfair discrimination by life insurers or insurance professionals on the basis of abuse status. Nothing in Sections 83-71-51 through 83-71-65 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-51 through 83-71-65.

**SOURCES: Laws, 2010, ch. 455, § 9, eff from and after July 1, 2010.**

### § 83-71-53. Applicability of Sections 83-71-51 through 83-71-65 to life insurers and insurance professionals issuing or renewing life insurance policies or certificates of life insurance in Mississippi.

Sections 83-71-51 through 83-71-65 apply to all life insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of life insurance.

**SOURCES: Laws, 2010, ch. 455, § 10, eff from and after July 1, 2010.**

### § 83-71-55. Definitions.

As used in Sections 83-71-51 through 83-71-65, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises, in whole or in part, out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(g) "Insured" means the person whose life is covered under an insurance policy.

(h) "Insurer" means a person or other legal entity engaged in the business of life insurance in this state.

(i) "Policy" or "certificate" means a contract of insurance or annuity including endorsements, riders or binders issued, proposed for issuance or intended for issuance by an insurer or insurance professional.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse or protection, court-ordered protection or shelter from abuse.

**SOURCES: Laws, 2010, ch. 455, § 11, eff from and after July 1, 2010.**

## § 83-71-57. Unfair discriminatory acts; life insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue, refuse to renew or reissue, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to a policy for an applicant or insured on the basis of the applicant's or insured's abuse status; or

(b) Exclude, limit or deny benefits on a life insurance policy on the basis of an insured's abuse status except as otherwise permitted or required by the laws of this state relating to acts of abuse committed by a life insurance beneficiary.

(2) When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information by a person employed by or contracting with an insurer or insurance professional for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-51 through 83-71-65 in all respects and to be subject to the enforcement of Sections 83-71-51 through 83-71-65 by the courts of this state for the benefit of the applicant or the insured, and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(iii) Medical or claims personnel contracting with the insurer or insurance professional, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer or insurance professional that have service agreements with the insurer or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the insurer or insurance professional effectively, if the insurer or insurance professional notifies the attorney of its obligations under Sections 83-71-51 through 83-71-65 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(g) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information about acts of abuse or abuse status or make use of that information, however obtained.

(4) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(5) Subsection (1) of this section does not prohibit an insurer or insurance professional from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and if:

(a) The applicant or prospective owner of the policy lacks an insurable interest in the insured;

(b) The applicant or prospective owner of the policy is known, on the basis of medical, police or court records, to have committed an act of abuse against the proposed insured; or

(c) The insured or prospective insured is a subject of abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

(6) Subsection (3) of this section does not prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-51 through 83-71-65 and other applicable law.

(7) An insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from any action taken in a good faith effort to comply with the requirements of Sections 83-71-51 through 83-71-65. However, this subsection does not prevent an action to investigate or enforce a violation of Sections 83-71-51 through 83-71-65 or to assert any other claims authorized by law.

**SOURCES: Laws, 2010, ch. 455, § 12, eff from and after July 1, 2010.**

### § 83-71-59. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

(d) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

**SOURCES: Laws, 2010, ch. 455, § 13, eff from and after July 1, 2010.**

## § 83-71-61. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals with which they contract for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-51 through 83 71-65 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

**SOURCES: Laws, 2010, ch. 455, § 14, eff from and after July 1, 2010.**

## § 83-71-63. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-51 through 83-71-65.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-51 through 83-71-65 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-51 through 83-71-65 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

**SOURCES: Laws, 2010, ch. 455, § 15, eff from and after July 1, 2010.**

## § 83-71-65. Applicability of Sections 83-71-51 through 83-71-65 to certain policies or certificates of life insurance and certain applications for coverage under a policy or certificate of life insurance.

Sections 83-71-51 through 83 71-65 apply to every policy or certificate that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a policy or certificate.

**SOURCES: Laws, 2010, ch. 455, § 16, eff from and after July 1, 2010.**

## DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE

| Sec. | |
|---|---|
| 83-71-101. | Purpose. |
| 83-71-103. | Applicability of Sections 83-71-101 through 83-71-115 to disability income insurers and insurance professionals issuing or renewing policies or certificates of disability income insurance in Mississippi. |
| 83-71-105. | Definitions. |
| 83-71-107. | Unfair discriminatory acts; disability income insurance. |
| 83-71-109. | Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action. |
| 83-71-111. | Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse. |
| 83-71-113. | Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-101 through 83-71-115. |
| 83-71-115. | Applicability of Sections 83-71-101 through 83-71-115 to certain policies or certificates of disability income insurance and certain applications for coverage under a policy or certificate of disability income insurance. |

## § 83-71-101. Purpose.

The purpose of Sections 83-71-101 through 83-71-115 is to prohibit unfair discrimination by disability income insurers and insurance professionals on the basis of abuse status. Nothing in Sections 83-71-101 through 83-71-115 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-101 through 83-71-115.

**SOURCES: Laws, 2010, ch. 455, § 17, eff from and after July 1, 2010.**

## § 83-71-103. Applicability of Sections 83-71-101 through 83-71-115 to disability income insurers and insurance professionals issuing or renewing policies or certificates of disability income insurance in Mississippi.

Sections 83-71-101 through 83-71-115 apply to all disability income insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of disability income insurance.

**SOURCES: Laws, 2010, ch. 455, § 18, eff from and after July 1, 2010.**

## § 83-71-105. Definitions.

As used in Sections 83-71-101 through 83-71-115, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or in part out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(g) "Insured" means a party named on a disability income policy or certificate as the person with legal rights to the benefits provided by the policy or certificate. For group insurance, "insured" includes a person who is a beneficiary covered by a group policy or certificate.

(h) "Insurer" means a person or other legal entity engaged in the business of disability income insurance in this state.

(i) "Policy" or "certificate" means a contract of insurance or indemnity, including endorsements, riders or binders issued, proposed for issuance or intended for issuance by an insurer or insurance professional.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse or protection, court-ordered protection or shelter from abuse.

**SOURCES: Laws, 2010, ch. 455, § 19, eff from and after July 1, 2010.**

## § 83-71-107. Unfair discriminatory acts; disability income insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue or renew, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to any disability income insurance policy on the basis of the applicant's or insured's abuse status; or

(b) Exclude or limit coverage for losses or deny a claim under a disability income insurance policy on the basis of an insured's abuse status.

(2) When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-101 through 83-71-115 in all respects and to be subject to the enforcement of Sections 83-71-101 through 83-71-115 by the courts of this state for the benefit of the applicant or insured and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(iii) Medical or claims personnel contracting with the insurer, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer that have service agreements with the insurer or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the insurer or insurance professional effectively, provided the insurer or insurance professional notifies the attorney of its obligations under Sections 83-71-101 through 83-71-115 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(g) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about the abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information about acts of abuse or abuse status or make use of that information, however obtained.

(4) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(5) Subsection (3) of this section does not prohibit a disability income insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-101 through 83-71-115 and other applicable law.

(6) A disability income insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from an action taken in a good faith effort to comply with the requirements of Sections 83-71-101 through 83-71-115. However, this subsection does not prevent an action to investigate or enforce a violation of Sections 83-71-101 through 83-71-115 or to assert any other claims authorized by law.

**SOURCES: Laws, 2010, ch. 455, § 20, eff from and after July 1, 2010.**

### § 83-71-109. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action and any applicable policy provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or disability without regard to whether the condition is abuse-related; and

(d) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

**SOURCES: Laws, 2010, ch. 455, § 21, eff from and after July 1, 2010.**

### § 83-71-111. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-101 through 83-71-115 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

**SOURCES: Laws, 2010, ch. 455, § 22, eff from and after July 1, 2010.**

### § 83-71-113. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-101 through 83-71-115.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-101 through 83-71-115 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-101 through 83-71-115 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

**SOURCES: Laws, 2010, ch. 455, § 23, eff from and after July 1, 2010.**

### § 83-71-115. Applicability of Sections 83-71-101 through 83-71-115 to certain policies or certificates of disability income insurance and certain applications for coverage under a policy or certificate of disability income insurance.

Sections 83-71-101 through 83-71-115 apply to every policy or certificate that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a policy or certificate.

**SOURCES: Laws, 2010, ch. 455, § 24, eff from and after July 1, 2010.**

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